IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TEXARKANA DIVISION

THE STATE OF TEXAS, Plaintiff	)	
VS.	)	CIVIL ACTION NO. 5-96CV91
THE AMERICAN TOBACCO COMPANY, ET AL	)	

COPY

ORAL DEPOSITION
OF
DEANN FRIEDHOLM

VOLUME II

AUGUST 14, 1997

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1 IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
2 TEXARKANA DIVISION

3

THE STATE OF TEXAS, Plaintiff	)	
VS.	)	CIVIL ACTION NO. 5-96CV91
THE AMERICAN TOBACCO COMPANY; R.J. REYNOLDS TOBACCO COMPANY; BROWN & WILLIAMSON TOBACCO CORPORATION; B.A.T. INDUSTRIES, P.L.C.; PHILIP MORRIS, INC.; LIGGETT GROUP, INC.; LORILLARD TOBACCO COMPANY, INC.; UNITED STATES TOBACCO COMPANY; HILL & KNOWLTON, INC.; THE COUNCIL FOR TOBACCO RESEARCH-USA, INC. (Successor to Tobacco Institute Research Committee); AND THE TOBACCO INSTITUTE, INC., Defendants	)	

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20 ORAL DEPOSITION OF DEANN FRIEDHOLM
VOLUME II

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1 ANSWERS AND DEPOSITION OF DEANN FRIEDHOLM,
2 VOLUME II, a witness called by the DEFENDANT PHILIP
3 MORRIS, taken before SALLY KING, Certified Court
4 Reporter for the State of Texas, on AUGUST 14,
5 1997, beginning at 8:10 a.m. and ending at 5:20
6 p.m., at the offices of the Attorney General of the
7 State of Texas, 300 West 15th Street, Austin, Texas
8 78701, pursuant to the Federal Rules of Civil
9 Procedure.
10
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11
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10 Also present:
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1 **EXHIBITS**

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1 **DEANN FRIEDHOLM, VOLUME II**

2 was called as a witness and, having been

3 first duly sworn, testified as follows:

4 **EXAMINATION**

5 BY MR. HAY:

6 THE VIDEOGRAPHER: The time is 8:10 08:

7 a.m. 08:

8 Q. Okay. Ms. Friedholm, I just want to remind 08:

9 you that you're still under oath. 08:

10 A. (Witness nods affirmatively.) 08:

11 Q. Let me show you what's been previously marked 08:

12 as Exhibit 4, which you've identified as your 08:

13 resume. And on the first page of it, the 08:

14 fourth bullet item under the "Texas Medicaid 08:

15 director, 1993 to September '95," there is a 08:

16 reference to "Oversaw implementation of the 08:

17 first two managed care projects for Medicaid 08:

18 in Texas." Do you see that? 08:

19 A. Yes. 08:

20 Q. It then states,"Which expanded" -- well, 08:

21 first of all, what -- those are the two 08:

22 managed care projects we spoke of yesterday, 08:

23 the Travis County and the tri-county? 08:

24 A. Yes, sir. 08:

25 Q. Okay. "Which expanded the provider base by 08:

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1 50 percent." Do you see that? 08:1
2 A. Uh-huh. 08:1
3 Q. What do you mean by that? 08:1
4 A. In those two areas we had been experiencing a 08:1
5 lack of providers who were willing to see 08:1
6 Medicaid patients, and through the process of 08:1
7 implementing managed care, we were able to 08:1
8 sign up, I believe it was 48 percent or 08:1
9 something like that. I mean, the exact 08:1
10 number was close to 50 percent, and it varied 08:1
11 between Austin and the tri-county area, with 08:1
12 tri-county having more doctors signing up to 08:1
13 participate in the program. And that -- so 08:1
14 that's the reference there. That was based 08:1
15 on the first-year experience. 08:1
16 Q. Okay. That was one of my questions. This 08:1
17 was based on what happened the first year? 08:1
18 A. I believe it was the first year. It may have 08:1
19 been slightly longer than the first year. 08:1
20 Q. Okay. And you said that the tri-county added 08:1
21 more. This is principally physicians? 08:1
22 A. Principally physicians, but not only. It 08:1
23 also included other providers. 08:1
24 Q. Okay. Approximately, just to give me a 08:1
25 sense, how many is a 50 percent increase? 08:1

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1 A. I couldn't tell you that off the top of my 08:
2 head. I'm sorry. 08:
3 Q. Yeah. You don't have any kind of ball park? 08:
4 A. I don't recall anymore. 08:
5 Q. And you said that the tri-county added more 08:
6 than the Travis County. Do you know 08:
7 approximately what percentage the Travis 08:
8 County increased? 08:
9 A. It was around 45 percent. 08:
10 Q. What do you attribute the increase to in 08:
11 those two counties? 08:
12 A. An improvement -- I believe -- well, frankly, 08:
13 I don't know. I mean, I don't know for a 08:
14 fact what the decisions of the providers were 08:
15 that changed their minds. There was no 08:
16 survey done of them. 08:
17 Q. Do you -- do you have any opinion or belief 08:
18 as to what it -- what was the motivation? 08:
19 A. We thought that to some extent it was a 08:
20 function of providers being given the 08:
21 opportunity to say, yes, that I will 08:
22 participate, but I will take X number of 08:
23 patients, which limited their exposure to 08:
24 being overwhelmed by Medicaid patients, which 08:
25 was being an experience that many doctors who 08:

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1 took Medicaid were having. Once you signed 08:1
2 up and said "I'm a Medicaid provider," then 08:1
3 you would be swamped with patients attempting 08:1
4 to come into your practice. And so we 08:1
5 thought that the opportunity of them to say, 08:1
6 "Yes, I'll take some and I'll take this 08:1
7 many" and have specific individuals as their 08:1
8 patients was an improvement for them. 08:1
9 Also in the tri-county area they 08:1
10 were paid a monthly management fee of $3 a 08:1
11 month, which was a slight improvement on the 08:1
12 -- on the Medicaid rate. And in Austin, at 08:1
13 least with the HMO, they were -- the primary 08:1
14 care physicians received higher office visit 08:1
15 payments through the HMO, which is all 08:1
16 negotiated independent of the state, but they 08:1
17 were offering better payments for seeing the 08:1
18 patients. So those were our thoughts about 08:1
19 it. 08:1
20 Q. Okay. The next phrase talks about "reduced 08:1
21 unnecessary use of emergency rooms for 08:1
22 private primary care." 08:1
23 A. Uh-huh. 08:1
24 Q. What's your basis for saying that? 08:1
25 A. A report that was done on those projects 08:1

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1 reviewing the use of emergency rooms in those 08:1
2 two projects. Again, I think it's the same 08:1
3 period of time. I was taking this from the 08:1
4 first -- from the report that -- it's the 08:1
5 same report. 08:1
6 Q. And do you know what report that was? Do you 08:1
7 know what title? 08:1
8 A. It was done by the Managed Care Bureau of TDH 08:1
9 and I don't recall the title, but it would 08:1
10 reference those two projects. 08:1
11 Q. Okay. Do you have any different information 08:1
12 that would change what is here in this 08:1
13 paragraph in terms of any subsequent 08:1
14 information about the results of those two 08:1
15 projects? 08:1
16 A. I personally don't. There may be some more 08:1
17 recent analysis. 08:1
18 Q. Okay. No, that's fair enough. I just want 08:1
19 to understand if you were aware of any 08:1
20 updated information that would, you know, say 08:1
21 it really wasn't 50 percent provider base 08:1
22 increase, but something else? 08:1
23 A. Not that I have. 08:1
24 Q. Okay. Was there a difference in the amount 08:1
25 of the reduction of unnecessary use of 08:1

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1 emergency rooms between the two projects -- 08:
2 the two pilot projects? 08:
3 A. The Austin project with the HMO had a 08:
4 slightly better reduction. 08:
5 Q. Do you -- is there any way of quantifying 08:
6 that in -- in terms of dollars saved or 08:
7 encounters or emergency rooms or whatever? 08:
8 A. Again, I would have to refer you to the 08:
9 review of the program -- that same review. 08:
10 Q. Was there any feedback as to why the Austin 08:
11 project had better or a greater reduction of 08:
12 emergency room? 08:
13 A. The HMO was very aggressive at the beginning 08:
14 of the project to station people in the -- in 08:
15 the emergency room to help educate 08:
16 individuals to help them change their 08:
17 patterns of use of the services and they 08:
18 reported that it had improved -- that, you 08:
19 know, while people would receive service that 08:
20 one time, they were more likely to go through 08:
21 their primary care doctor after that. 08:
22 Q. Okay. The next phrase is "Increased 08:
23 preventive services, EPSDT and 08:
24 immunizations." Was there a difference 08:
25 between the amount of increased preventive 08:

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1 services between the two projects? 08:2
2 A. I don't know. I don't recall. 08:2
3 Q. Is there any way of quantifying how much -- 08:2
4 how much there was an increase in preventive 08:2
5 services? 08:2
6 A. I believe that same set of data include those 08:2
7 measures for you. 08:2
8 Q. Okay. You don't sitting here today recall 08:2
9 what those -- that increase was? 08:2
10 A. No. It had been a big problem, so it was a 08:2
11 good increase. 08:2
12 Q. What had been a big problem? 08:2
13 A. The lack of preventive service -- the lack of 08:2
14 EPSDT screens and immunizations, our 08:2
15 immunization rate in the whole State of Texas 08:2
16 for all of our kids. 08:2
17 Q. And you're talking about in the Medicaid 08:2
18 program? 08:2
19 A. I'm speaking generally and then specifically 08:2
20 with the Medicaid program. 08:2
21 Q. Okay. And these managed care pilots were 08:2
22 very helpful in increasing those preventive 08:2
23 services? 08:2
24 A. Yes. 08:2
25 Q. Okay. Then the next item talks about "lower 08:2

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1 total state costs by five percent." 08:2
2 A. Uh-huh. 08:2
3 Q. Again, can you break down the improved or 08:2
4 lower cost by pilot? 08:2
5 A. I can't now. That was the original -- those 08:2
6 were the numbers that we had as of the first 08:2
7 year, as I said, and I'm not sure about 08:2
8 anything else since then. I mean, I've seen 08:2
9 references that PCCM has not been as cost -- 08:2
10 or savings compared to fee for services, the 08:2
11 HMO model, but I can't cite it back to those 08:2
12 specific years or those specific projects. 08:2
13 Q. Okay. And were you aware of -- so when you 08:2
14 were referencing -- strike that. 08:2
15 When you're referencing the lower 08:2
16 total state costs, you're talking this is a 08:2
17 combination of the two projects overall? 08:2
18 A. I believe that's right. 08:2
19 Q. And sitting here today, you don't know how 08:2
20 the projects individually broke down? 08:2
21 A. Well, subsequent -- I mean, in reading the 08:2
22 updated "Texas Medicaid in Perspective," they 08:2
23 had more recent data which I just reviewed, 08:2
24 and it indicates that the HMO model has saved 08:2
25 3.7 or 4 percent, something like that, while 08:2

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1 the tri-county longer experience was an 08:
2 increase. 08:
3 Q. So it actually -- the PCCM actually was more 08:
4 costly than under the original fee for 08:
5 service? 08:
6 A. That's what is stated in "Texas Medicaid in 08:
7 Perspective," the most recent volume. 08:
8 Q. Aside from what is stated there, you don't 08:
9 have any other additional knowledge? 08:
10 A. I don't. 08:
11 Q. Now, I want to direct your attention back to 08:
12 Exhibit 3, which we were talking about in 08:
13 some length, your list of opinions and -- 08:
14 strike that. 08:
15 Before -- before we get into any 08:
16 specific opinions, let me ask you this: Are 08:
17 you familiar with the reimbursement 08:
18 methodology used for outpatient hospital 08:
19 services? 08:
20 A. I am familiar with it. I'm not an expert 08:
21 about it. 08:
22 Q. Well, can you describe for us what the 08:
23 reimbursement methodology is for outpatient 08:
24 hospital services? 08:
25 A. We -- the State of Texas sets a rate for it. 08:

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1 And it's a perspective rate, and that's what 08:2
2 they're paid. I'm not sure that I understand 08:2
3 what you're driving at. 08:2
4 Q. Well, I'm directing -- I'm specifically 08:2
5 outpatient hospital services which could -- 08:2
6 would include emergency rooms, correct? 08:2
7 A. Yes. 08:2
8 Q. Okay. And it's your testimony that your 08:2
9 understanding is that there's a perspective 08:2
10 rate that is set for those services? 08:2
11 A. I believe so. 08:2
12 Q. Okay. Do you recall any -- are you aware of 08:2
13 any discussions about or recommendations to 08:2
14 change the methodology for outpatient 08:2
15 reimbursement? 08:2
16 A. Not specifically, no. 08:2
17 Q. Are you aware of any recommendation to 08:2
18 reimburse nonemergency care provided in an 08:2
19 outpatient setting at the rate used by -- in 08:2
20 a physician's office? 08:2
21 A. I'm not getting any specific memory of that, 08:2
22 no. 08:2
23 Q. Are you familiar with the reimbursement 08:2
24 methodology used for pharmacy services? 08:2
25 A. Somewhat, yes. 08:2

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1 Q. Okay. Can you briefly describe what that 08:
2 reimbursement methodology is? 08:
3 A. The state pays a fee for the prescription, 08:
4 the drug itself, and then a dispensing fee to 08:
5 the pharmacy. 08:
6 Q. Does the -- do you know how the dispensing 08:
7 fee is established? 08:
8 A. How it is established? 08:
9 Q. Right. Or what are the elements? What's 08:
10 included in the dispensing fee? 08:
11 A. I can't say. 08:
12 Q. Is there a profit factor in the dispensing 08:
13 fee? 08:
14 A. I believe so. 08:
15 Q. Has Texas been criticized for an overly 08:
16 generous or excessive profit factor in its 08:
17 dispensing fee over the years? 08:
18 A. I believe so, yes. 08:
19 Q. Okay. Has that recently been changed in 08:
20 terms of the profit factor in the dispensing 08:
21 fee? 08:
22 A. There have been actions taken to change it. 08:
23 I don't know that it's actually been 08:
24 implemented. 08:
25 Q. Do you know what the profit factor during 08:

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1 your tenure as Medicaid director was? 08:2
2 A. No, I can't recall anymore. 08:2
3 Q. Do you know if there's been any criticisms 08:2
4 concerning the ingredient cost and how that's 08:2
5 calculated by Texas? 08:2
6 A. I don't recall that. 08:2
7 Q. Do you know if there's been any changes in 08:2
8 the method of computing the cost -- the 08:2
9 ingredient cost in the pharmacy 08:2
10 reimbursement? 08:2
11 A. No, I don't know. 08:2
12 Q. I believe we touched on this briefly. Are 08:2
13 you aware of how patients get admitted to 08:2
14 nursing homes, what's the process? 08:2
15 A. They are reviewed and a physician signs off 08:2
16 on their level of need for care that has to 08:2
17 meet a standard that the state sets. 08:2
18 Q. So it's basically on a physician 08:2
19 recommendation? 08:2
20 A. It's my understanding. 08:2
21 Q. Is there any preadmission screening by the 08:2
22 state itself prior to a patient entering a 08:2
23 nursing facility? 08:2
24 A. I think there is now. 08:2
25 Q. Do you know when that was implemented? 08:2

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1 A. '94 or '5. 08:2
2 Q. Do you know why that was implemented? 08:2
3 A. An attempt to make sure that individuals were 08:2
4 aware of any other community-based options if 08:2
5 they were available in their community. 08:2
6 Q. Any other reason? 08:2
7 A. Well, an underlying assumption in that is 08:2
8 that, at least for most cases, that would be 08:2
9 less expensive. 08:2
10 Q. Well, aside from doing a preadmission 08:2
11 screening to advise the patient of other 08:2
12 options, was there any other purpose to the 08:2
13 preadmission screening other than just to 08:2
14 advise them of their options? And by that I 08:2
15 mean was it -- was there a determination made 08:2
16 or an attempt to determine activities of 08:2
17 daily living or any kind of prescreening in 08:2
18 that sense? 08:2
19 A. Yes. 08:2
20 Q. Okay. Why was that implemented in 1994 or 08:2
21 '95? 08:2
22 A. I don't remember a specific cause, again, 08:2
23 beyond what I've already said. 08:2
24 Q. Was there a problem or a concern about 08:2
25 admissions based solely on doctor's notes or 08:2

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1 recommendations to -- as not -- as in fact 08:
2 admitting patients who didn't really need 08:
3 nursing homes? Is that one of the reasons 08:
4 why the prescreen -- prescreening started? 08:
5 A. Not that I recall. 08:
6 Q. That wasn't -- that wasn't an issue or 08:
7 concern at the time? 08:
8 A. The primary concern was that we had expanded 08:
9 the numbers of community care options 08:
10 available and that special efforts needed to 08:
11 be made to make sure that people were aware 08:
12 of those options and that the previous 08:
13 limitations were not particularly still the 08:
14 case. 08:
15 Q. You mentioned these community-based options. 08:
16 That's commonly known as the community-based 08:
17 alternative waiver, if you will? 08:
18 A. There are a number, but yes, that's one of 08:
19 them. 08:
20 Q. When was the community-based alternative -- 08:
21 alternatives implemented in Texas? And I'm 08:
22 talking about the waiver program. 08:
23 A. I can't name a specific year. 08:
24 Q. Approximately? Was it during your tenure or 08:
25 was it -- 08:

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1 A. '93 perhaps, '94, in that -- in that period 08:3
2 of time. 08:3
3 Q. Okay. Was there any analysis done as to what 08:3
4 the -- any studies in that analysis as to 08:3
5 what the effect of the program will be on 08:3
6 cost? 08:3
7 A. Well, in order to implement the program, we 08:3
8 had to do estimates of the cost impact, but I 08:3
9 don't know about any follow-up surveys or 08:3
10 studies. 08:3
11 Q. You mentioned before that in most cases the 08:3
12 belief is that the community based is less 08:3
13 expensive than the nursing home for a 08:3
14 patient. 08:3
15 A. On average, yes. 08:3
16 Q. Do you know approximately what the difference 08:3
17 is between the two? 08:3
18 A. Not for that specific program. 08:3
19 Q. Is there any information that would contain 08:3
20 that? 08:3
21 A. Yes. 08:3
22 Q. What would that be? 08:3
23 A. The state keeps that data. 08:3
24 Q. In what form? If I want the data, how do I 08:3
25 ask your attorney for it? What do I -- what 08:3

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1 document would I ask for? 08:3
2 A. I don't know that I can give you the name. I 08:3
3 would just go to the long-term care group 08:3
4 in -- in DHS and say, "I need information on 08:3
5 the costs of these programs relative to 08:3
6 nursing home." They'd have to report that to 08:3
7 HCFA, but I'm sorry, I'm not remembering the 08:3
8 name of the report. 08:3
9 Q. Okay. Has the community-based alternative 08:3
10 program been as extensive -- as extensive as 08:3
11 it could be in your estimation? 08:3
12 A. I think it has -- no, I do not think it has 08:3
13 been as extensive as it will be, but the 08:3
14 implementation process has been -- has taken 08:3
15 a while. 08:3
16 Q. And why is that? 08:3
17 A. It's a big state. They've gone region by 08:3
18 region. The nursing home industry has not 08:3
19 been particularly supportive of it. Those 08:3
20 are the reasons. 08:3
21 Q. Well, how large is the program now? 08:3
22 A. I don't know. 08:3
23 Q. When do you think it would be fully 08:3
24 implemented? 08:3
25 A. I'm not sure. 08:3

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1 Q. Do you have any projection? 08:3
2 A. No. 08:3
3 Q. Your testimony is that -- and I know this is 08:3
4 an approximation -- that the program started 08:3
5 in about 1993, '94. Do you know when 08:3
6 community-based alternatives were first 08:3
7 discussed in Texas as a possible -- as a 08:3
8 possible alternative through the waiver 08:3
9 program to nursing homes? 08:3
10 A. As an alternative to nursing homes? 08:3
11 Q. Right. 08:3
12 A. No, I don't know a specific date. 08:3
13 Q. Would it surprise you to learn that 08:3
14 community-based alternatives have been in 08:3
15 effect in other states since -- into the 08:3
16 early '80s? 08:3
17 A. No, I don't think it would surprise me. 08:3
18 Q. Do you know any reason why Texas didn't 08:3
19 implement these community-based alternatives 08:3
20 earlier than they have? 08:3
21 A. No, I really don't know. 08:3
22 Q. And you said in terms of the implementation 08:3
23 process taking awhile, as I understand it, 08:3
24 you're saying, well, it's a big state, which 08:3
25 I will grant you, but what do you mean by 08:3

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1 that? Is that a matter of resources on the 08:3
2 state side or what's the significance of it 08:3
3 being a big state? 08:3
4 A. The -- I really don't know that I can answer 08:3
5 that. I know that the decision was made to 08:3
6 implement on a region-by-region basis to test 08:3
7 out the best way to do that, to do the 08:3
8 implementation. And beyond that, I don't 08:3
9 recall.
10 Q. And do you know the reason for the decision 08:3
11 to implement on a region-by-region basis? 08:3
12 A. No. 08:3
13 Q. Were you a supporter of that decision to 08:3
14 implement on a kind of region-by-region 08:3
15 basis? 08:3
16 A. I don't recall having an opinion about it. I 08:3
17 remember being told that that was the way the 08:3
18 agency recommended going and I didn't dispute 08:3
19 it. 08:3
20 Q. Okay. Who at the agency recommended that? 08:3
21 A. The long-term care division at DHS. 08:3
22 Q. Is there a person in particular who was the 08:3
23 proponent of the region-by-region 08:3
24 implementation? 08:3
25 A. Tony Venza was the head of that unit and was 08:3

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1 the person who put forward the 08:
2 recommendation. Beyond that, I don't know. 08:
3 Q. Was Linda Wertz involved in that, do you 08:
4 recall?
5 A. No. 08:
6 Q. You don't recall or she wasn't involved? 08:
7 A. No, she was not involved. 08:
8 Q. Okay.
9 A. To my knowledge. 08:
10 Q. We touched on this a little bit at the first 08:
11 of your deposition, which is the issue of 08:
12 personal care. And if I can direct your 08:
13 attention to the primary home care, and by 08:
14 that I'm talking about the nonpriority one 08:
15 client. Is that -- do you know what I'm 08:
16 referring to? 08:
17 A. Generally. 08:
18 Q. Okay. That's kind of part of the nonwaiver 08:
19 group, correct? 08:
20 A. It's a regular service under the regular 08:
21 Medicaid program. 08:
22 Q. Okay. What kind of services did they 08:
23 provide? 08:
24 A. An attendant would come out to help for a 08:
25 number of duties that an individual would 08:

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1 need assistance with in order to have the 08:3
2 activities of daily living. 08:3
3 Q. Can you give us some examples? 08:3
4 A. Cooking -- 08:3
5 Q. Okay. Thank you.
6 A. -- bathing, dressing. 08:3
7 Q. Okay. But we're not talking about really 08:3
8 true medical services. These are more 08:3
9 services in the nature of assisting people 08:3
10 in, just as you said, activities of daily 08:3
11 living? 08:3
12 A. Right. 08:3
13 Q. Do you know if any private insurance 08:3
14 companies in Texas pay for similar services? 08:3
15 A. I don't know. 08:3
16 Q. How are those services reimbursed? What's 08:3
17 the methodology of reimbursement? 08:3
18 A. I believe we set a daily rate for different 08:3
19 levels of service. 08:3
20 Q. So is that some kind of cost report basis 08:3
21 or -- 08:3
22 A. I don't know. 08:3
23 Q. Do you know how those services are audited, 08:3
24 if they are? 08:3
25 A. I don't know. 08:3

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1 Q. Do you know who oversees those services in 08:3
2 terms -- and by oversee them, I mean who 08:3
3 would audit or check to make sure that the 08:3
4 reimbursement is correct? 08:3
5 A. I can't say positively. I have no reason to 08:3
6 think it's different than the rest of the 08:3
7 program, but I don't know. 08:3
8 Q. What do you mean when you say "reason to 08:3
9 think it's different than the rest of the 08:3
10 program"? 08:3
11 A. That it wouldn't go through the same review 08:3
12 process, same utilization review, claims 08:3
13 review. 08:3
14 Q. Okay. Well, let me kind of illustrate my 08:4
15 point. You're -- are you familiar with the 08:4
16 methodology for inpatient hospital 08:4
17 reimbursement? 08:4
18 A. Yes. 08:4
19 Q. Okay. And that's the DRG system which we 08:4
20 spoke about briefly the last time? 08:4
21 A. Yes. Well -- 08:4
22 Q. Correct?
23 A. -- selective contracting. 08:4
24 Q. Okay. Selective contracting now. How are 08:4
25 audits done -- strike that. 08:4

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1 Is that reimbursement system based 08:4
2 on cost reports, the DRG system to the extent 08:4
3 that you're still utilizing that? 08:4
4 A. Yes. 08:4
5 Q. Okay. Who audits the cost reports, if 08:4
6 anyone? 08:4
7 A. Who audits them? 08:4
8 Q. Yes. 08:4
9 A. They go through the same review process for 08:4
10 utilization review and claims auditing that 08:4
11 other Medicaid bills go through. 08:4
12 Q. Well, I'm talking about an audit not from 08:4
13 a -- not a utilization review in the 08:4
14 utilization review sense of checking to see 08:4
15 whether the services were required. I'm 08:4
16 talking about the actual cost reports that 08:4
17 form the basis for the -- for establishing 08:4
18 the standard dollar amounts in the DRGs -- 08:4
19 within the DRGs. Who audits the cost 08:4
20 reports? 08:4
21 A. I can't name who does that. 08:4
22 Q. Does the State of Texas do it or do they hire 08:4
23 someone else to do it or NHIC? Who -- you 08:4
24 know, what --
25 A. I can't say. 08:4

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1 Q. Okay. Let me now move to your statement of 08:4
2 opinions again. And we're on the second 08:4
3 page, and I think we're on the first full 08:4
4 paragraph. It says, "Ms. Friedholm will 08:4
5 testify that Texas contracted with National 08:4
6 Heritage Insurance Company in order to 08:4
7 minimize inappropriate payment of claims." 08:4
8 Is that a fact or are you going to render 08:4
9 some opinion concerning that area? 08:4
10 A. It's both. 08:4
11 Q. Okay. What opinion are you going to render 08:4
12 concerning Texas' contract with National 08:4
13 Heritage Insurance Company?
14 A. That the state has chosen to through the 08:4
15 years use a joint risk-sharing arrangement 08:4
16 with NHIC as opposed to a -- the alternative 08:4
17 that other states use, which is a third-party 08:4
18 administrator bill-paying kind of approach. 08:4
19 And that in order to -- that one of the 08:4
20 reasons that the state continues to choose or 08:4
21 has continued to choose to do that, at least 08:4
22 for the regular program, the nonmanaged care 08:4
23 program, has been that it sets incentives and 08:4
24 goals for NHIC to make sure that the claims 08:4
25 payment process functions accurately. 08:4

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1 Q. And what are the incentives and goals that 08:4
2 they set for NHIC? How is that done in the 08:4
3 arrangement? 08:4
4 A. Through setting of a premium rate, which they 08:4
5 share in the extra if we come in under the 08:4
6 amounts that we have established as premiums, 08:4
7 and conversely, in the event that we should 08:
8 have an over -- an overage, they can be held 08:
9 responsible for up to a certain stop loss, a 08:
10 relatively small stop loss, but it's still 08:
11 millions of dollars, amount of money for the 08:
12 program. And so there is -- they share with 08:
13 us an incentive to try to make sure that the 08:
14 only payments that are made are correct 08:
15 payments. 08:
16 Q. They share -- 08:
17 A. Go ahead. 08:
18 Q. Sorry. They share on the up side -- their 08:
19 share of the up side is limited as well, 08:
20 correct? 08:
21 A. Yes. 08:
22 Q. Okay. Have they ever been -- have they ever, 08:
23 in fact, had to chair on the downside? 08:
24 A. I don't believe they've ever shared on the 08:
25 downside. 08:

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1 Q. Have they -- have the premiums under this 08:4
2 program been set so high that in virtually 08:4
3 every year, they've met their maximum upside 08:4
4 potential? 08:4
5 A. I don't know if they've met their maximum in 08:4
6 every year. We always tried to be as 08:4
7 accurate as we could be in setting a premium 08:4
8 rate that -- that met the budgetary 08:4
9 requirements that we had for the program. 08:4
10 Q. Well, sitting here today, can you identify 08:4
11 any year in which they didn't meet their 08:4
12 maximum profit? 08:4
13 A. I cannot name a year. 08:4
14 Q. Do you have a recollection that there was a 08:4
15 year that they did that, that they didn't 08:4
16 achieve the maximum profit under the 08:4
17 contract? 08:4
18 A. No. 08:4
19 Q. By the way, you said that this is for the -- 08:4
20 this applies to the nonmanaged care program. 08:4
21 A. Uh-huh. 08:4
22 Q. When the State of Texas fully implements its 08:4
23 managed care program as it's now designed, 08:4
24 what is going to be left in terms of -- in 08:4
25 the insurance arrangement? What parts of the 08:4

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1 program? 08:4
2 A. Those individuals who cannot be in managed 08:4
3 care or which the state has chosen not to 08:4
4 pursue managed care, and it's potentially 08:4
5 children with special health care needs or 08:4
6 individuals who have special health care 08:4
7 needs that managed care does not adequately 08:4
8 address, the state is in the process of 08:4
9 testing out different ways to include those 08:4
10 individuals in projects, in managed care, but 08:4
11 that would be the potential -- those would be 08:4
12 the potential groups that we think could 08:4
13 possibly remain outside of managed care. 08:4
14 Q. But it is potentially -- it is possible that 08:4
15 all of the recipients that are currently 08:4
16 under -- included under the insurance 08:4
17 arrangement might be included in managed 08:4
18 care? 08:4
19 A. The vast numbers of them, and potentially all 08:4
20 of them. That's much more uncertain. 08:4
21 Q. When you mentioned children with special 08:4
22 needs or people with special needs who 08:4
23 might -- who the state is now considering 08:4
24 ways to include in managed care, what -- can 08:4
25 you give me some estimate in terms of numbers 08:4

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1 of recipients that that might be of the, what 08:
2 is it, 2.5 million recipients? 08:
3 A. I can't give you a good estimate off the top 08:
4 of my head. It is not a large number. 08:
5 Q. I mean, is it like 10,000 or -- 08:
6 A. No, it's more than that. 08:
7 Q. Okay. No -- any order of magnitude estimate? 08:
8 A. I feel comfortable that I-- 08:
9 Q. Okay.
10 A. -- know well enough. 08:
11 Q. Fair enough. This insurance arrangement, you 08:
12 said, first of all, Texas is the only state 08:
13 that has an arrangement like this, correct? 08:
14 A. That has been my understanding. I just 08:
15 reviewed the "Medicaid in Perspective," the 08:
16 new version, and they mentioned that there's 08:
17 a second state, and I'm not aware of who that 08:
18 is. 08:
19 Q. Is that a -- is that second state -- you're 08:
20 talking about the '97 version of "Medicaid in 08:
21 Perspective"?
22 A. It's the '96 version, I think. 08:
23 Q. '96.
24 A. Whatever the most recent, the second edition. 08:
25 Q. Okay. And in it, it doesn't identify what 08:

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1 state that is? 08:4
2 A. No. 08:4
3 Q. Okay. 08:4
4 A. And it surprised me. 08:4
5 Q. Why does it surprise you? 08:4
6 A. Well, just because we have long been the only 08:4
7 state that has used that arrangement. 08:4
8 Q. Why is that? 08:4
9 A. Why is that? 08:4
10 Q. Right. 08:4
11 A. Originally, the state in deciding how to 08:4
12 implement Medicaid, the desire of the state 08:4
13 leadership was to use an insured arrangement 08:4
14 so that they could take advantage of the 08:4
15 expertise of that industry in running a 08:5
16 program that they otherwise didn't really 08:5
17 have the ability to do or the desire to gain 08:5
18 the ability to do. And since then, there 08:5
19 have been reviews of whether to continue it 08:5
20 or not, and in each instance the state has 08:5
21 determined that it has been more of a benefit 08:5
22 to the state in how Medicaid is handled. 08:5
23 Q. And do you recall what the benefits that have 08:5
24 been identified are, why that system is more 08:5
25 beneficial to the state than the system that 08:5

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1 the 49 other states use, or 48 perhaps? 08:5
2 A. Well, those states, some of them 08:5
3 self-administer and some of them contract 08:5
4 out. So it's not like they're all exactly 08:5
5 the same. But I don't know that I can speak 08:5
6 to the decision back in the early '80s as to 08:5
7 what they decided, but when we did some 08:5
8 reviews of the program compared with other 08:5
9 state programs which was conducted in the 08:5
10 early 1990s, it came down to you could tinker 08:5
11 with it one way or the other, but it was 08:5
12 certainly as good and held out opportunities 08:5
13 for the state to tighten it up in order to 08:5
14 make it a beneficial -- make it more 08:5
15 beneficial to the state. And so the decision 08:5
16 was to continue that approach, while we got 08:5
17 ready to move to a very major contract change 08:5
18 to accommodate the managed care developments 08:5
19 in the state. 08:5
20 Q. Well, was the decision -- are you explaining 08:5
21 the decision as being we'll leave well enough 08:5
22 alone because we're changing the managed care 08:5
23 anyway or was there some perceived benefit 08:5
24 when you did this analysis in the '90s for we 08:5
25 really should keep this program -- this 08:5

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1 insured arrangement for some specific 08:5
2 beneficial reasons? 08:5
3 A. The decision was that it was as good, if not 08:5
4 better, than the other approach, and we did 08:5
5 not want to have to go through a major 08:5
6 rebidding, which would be very disruptive to 08:5
7 the program at that time. So we stayed with 08:5
8 it. We didn't have any reason to think it 08:5
9 was -- that the other -- the other approach 08:5
10 was worth the problem of the transition that 08:5
11 we would -- we would face at a time when we 08:5
12 were trying to implement managed care as 08:5
13 well. 08:5
14 Q. Who was it who conducted the study? 08:5
15 A. Lewin. 08:5
16 Q. Did Lewin, in fact, recommend that the state 08:5
17 change to a fiscal agent system? 08:5
18 A. Not that I know of. 08:5
19 Q. The -- and I take it you said for the -- for 08:5
20 years prior to 1990, you're not aware of in 08:5
21 terms of analysis of benefits versus 08:5
22 disadvantages for this program? 08:5
23 A. I can't speak to those personally. 08:5
24 Q. Just to put all this in context, your next -- 08:5
25 the next sentence talks about "Ms. Friedholm 08:5

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1 will further testify that the state's 08:5
2 contract with NHIC provides for a high level 08:5
3 of scrutiny on the processing and payment of 08:5
4 claims." I take it that's your opinion? 08:5
5 A. Yes. 08:5
6 Q. What's that based on? 08:5
7 A. On the terms of the contract where we asked 08:5
8 them to -- or part of the contract is that 08:5
9 they will provide data and do review of 08:5
10 claims and that they do that. 08:5
11 Q. So what are -- in terms of documentation 08:5
12 you're relying on this for this -- this 08:5
13 opinion, what documents would you cite to? 08:5
14 A. Well, the contract itself lays out the 08:5
15 state's expectations of NHIC's payment of the 08:5
16 claims and review of the accuracy of that. 08:5
17 And generally other documents I can't cite 08:5
18 specifically, but we -- but NHIC was very 08:5
19 careful about reviewing claims for 08:5
20 appropriateness and had a very good level 08:5
21 of -- I don't know the exact term to use -- 08:5
22 of all the bills that would come in, they had 08:5
23 a relatively low rate of bills they actually 08:5
24 paid of those claimed. And there was, if 08:5
25 anything, concern on the part of the provider 08:5

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1 community that they were too conservative in 08:5
2 what they paid in terms of claims filed. 08:5
3 Q. Well, let me first start with, can you tell 08:5
4 us what in the contract itself, what 08:5
5 provisions of the contract provided for this 08:5
6 high level of scrutiny? 08:5
7 A. I would have to see the contract and go 08:5
8 through it. I'm sorry. I don't -- I can't 08:
9 cite them off the top of my head. 08:
10 Q. Well, this -- I will share with you what has 08:
11 been given to us with your -- your list of 08:
12 opinions, which is -- and has been described 08:
13 as additional documents not yet disclosed 08:
14 which are now disclosed, which as I 08:
15 understand it, are the contract and various 08:
16 amendments. 08:
17 A. Uh-huh.
18 Q. And my first question about that is, are 08:
19 these the documents, the contract and 08:
20 amendments that you're referring to, when you 08:
21 talk about the contract has a high level of 08:
22 scrutiny? 08:
23 A. Yes. 08:
24 Q. Okay. What about prior contracts prior to 08:
25 this 1989 version? Have you looked at those 08:

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1 to determine the level of scrutiny of claims? 08:5
2 A. I have not looked at those. 08:5
3 Q. Okay. There -- I am correct there were a 08:5
4 number of contracts prior to the '89 contract 08:5
5 with NHIC? 08:5
6 A. There were two or three. 08:5
7 Q. Okay. 08:5
8 A. I don't know a number. 08:5
9 Q. Okay. Have you reviewed or looked at any of 08:5
10 the provisions of those contracts to 08:5
11 determine the level of scrutiny required for 08:5
12 processing and payment of claims? 08:5
13 A. No. 08:5
14 Q. Are you aware of the provisions of those 08:5
15 contracts in terms of the level of scrutiny, 08:5
16 processing and payment of claims? 08:5
17 A. No. 08:5
18 Q. But -- so is your opinion just limited to 08:5
19 this '89 contract, or does it go back to the 08:5
20 entire existing -- the entire contractual 08:5
21 relationship with NHIC? 08:5
22 A. I would need to limit it to the one that I'm 08:5
23 familiar with. 08:5
24 Q. Okay. Which is the '89 -- 08:5
25 A. Yes. 08:5

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1 Q. Okay. Now -- okay. Let's -- I'll start off 08:5
2 by asking you since -- you know, in fairness, 08:5
3 since you said you needed to look at the 08:5
4 contract and the exhibits, I'll let you do 08:5
5 that. 08:5
6 MR. HAY: Why don't we go off the 08:5
7 record, take a few minutes. 08:5
8 THE VIDEOGRAPHER: Stand by, 08:5
9 please. The time is 8:59. We're going off 08:5
10 the record. 08:5
11 (OFF THE RECORD) 08:5
12 (RECESS) 08:5
13 THE VIDEOGRAPHER: The time is 9:23 09:2
14 a.m. We're on the record. 09:2
15 Q. Ms. Friedholm, have you had an opportunity to 09:2
16 review those documents which have been 09:2
17 produced as additional documents you're 09:2
18 relying on and, as I understand it, represent 09:2
19 the 1989 contract and some amendments to the 09:2
20 NHIC contract? 09:2
21 A. Yes, I briefly reviewed it. And -- 09:2
22 MR. HART: Let him ask the 09:2
23 questions. 09:2
24 Q. Okay. Well, you were reviewing it for 09:2
25 purposes of identifying provisions that 09:2

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1 relate to the level of scrutiny on the 09:
2 processing and payment of claims? 09:
3 A. Yes. 09:
4 Q. And which provisions have you identified as 09:
5 relating to that issue? 09:
6 A. There are requirements within the document -- 09:
7 throughout the document which establish the 09:
8 responsibilities of NHIC for the proper 09:
9 payment of claims under the Medicaid program 09:
10 and that they must meet all of the federal 09:
11 requirements for doing so. And in 09:
12 particular, I would say the section entitled 09:
13 "Duties of the Contractor," which goes on 09:
14 for a number of pages and details exactly 09:
15 what they have to do to pay claims correctly 09:
16 and in a timely basis, and also for many of 09:
17 the technical details which have to do with 09:
18 coordinating payments for dually eligible 09:
19 individuals and on and on. 09:
20 It also references then to a number 09:
21 of exhibits in the back that are more 09:
22 specific that have to do with S/URS, 09:
23 surveillance, utilization control, data 09:
24 provision for that, recoupment, payback 09:
25 penalties if they do not meet the terms of 09:

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1 the timeliness and the correctness of the 09:2
2 payments, and so these are very specific 09:2
3 cites in addition to what has been the 09:2
4 practice for how they are paid, which is, 09:2
5 generally speaking, I think, the point that 09:2
6 we've been talking about, and that point 09:2
7 being that they have an incentive as showed 09:2
8 by the way that the contract is financed and 09:2
9 structured. They have an incentive to not 09:2
10 pay any claims that they don't have to 09:2
11 because they benefit as a result of coming in 09:2
12 under what the cost of the program or what 09:2
13 the estimates for the program were going to 09:2
14 be. 09:2
15 And so I would maintain that the 09:2
16 entire document, but specifically those 09:2
17 sections that lay out in detail their duties 09:2
18 as our contractor for paying claims, show a 09:2
19 relationship where -- in which they are 09:2
20 incentivized to pay only correct claims and 09:2
21 as little as they can justify paying, which 09:2
22 is, I would contend, different than a 09:2
23 straight line administrative -- 09:2
24 administrative third-party administrator who 09:2
25 just merely pays claims. 09:2

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1 Q. Okay. Could I have the document, please? 09:2
2 MR. HAY: What I'm going to ask the 09:2
3 court reporter to do is to mark this as 09:2
4 collective Exhibit 5. And for the record, 09:2
5 these are the documents that have been 09:2
6 produced as additional, not previously 09:2
7 disclosed documents for this witness that the 09:2
8 witness is relying on. 09:2
9 (Deposition Exhibit No. 5 09:2
10 (marked for identification.
11 Q. Now, in terms of the provisions that talk 09:2
12 about the scrutinizing and the processing -- 09:2
13 well, the processing and payment of claims, 09:2
14 are you familiar with provisions in contracts 09:2
15 for fiscal agents who -- or paying 09:2
16 administrators for other states? 09:2
17 A. Not in detail. 09:2
18 Q. Are they -- do you know if those contracts 09:2
19 have requirements that are different in terms 09:2
20 of claims payment and processing than what's 09:2
21 included in the Texas contract? 09:2
22 A. No. 09:2
23 Q. So you don't know whether -- whether or not 09:2
24 comparatively speaking the requirements in 09:2
25 terms of processing and payment of claims in 09:2

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1 Texas are any more stringent or less 09:2
2 stringent than any other state? 09:2
3 A. No. 09:2
4 Q. Okay. And that's not something you thought 09:2
5 you needed to find out in order to render 09:2
6 this opinion? 09:2
7 A. I believe that our contract -- the State of 09:2
8 Texas contract by virtue of having them share 09:2
9 in the -- any funds that are left over at the 09:2
10 end of the year gives them a different kind 09:2
11 of incentive for the payment of claims. 09:2
12 Q. I understand that's your testimony. But in 09:2
13 terms of the actual claiming process and 09:2
14 payment requirements, you don't know one way 09:2
15 or another whether or not these are -- the 09:2
16 requirements of the Texas contract are 09:2
17 stringent at all, do you, as compared to 09:2
18 other states? 09:2
19 A. Not as compared to other states. I believe 09:2
20 they are stringent. 09:2
21 Q. What's your basis for believing they're 09:2
22 stringent? 09:2
23 A. Because it provides an enormous incentive for 09:2
24 them to be very conservative in their 09:2
25 payments and because through the years one of 09:2

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1 the major problems that we have had to deal 09:2
2 with is the doctors' perception that they 09:2
3 were being too stringent in their payments or 09:2
4 refusal to pay claims. 09:2
5 Q. Aside from doctors, have you gotten that 09:2
6 complaint from any other provider? 09:2
7 A. Hospitals. 09:2
8 Q. Okay. Any other provider? 09:2
9 A. Not that I can cite. 09:2
10 Q. How prevalent have those complaints been over 09:2
11 the years? Is it something that's continuing 09:2
12 today, as far as you know, or is that -- 09:2
13 A. I can't speak to today, but I can say through 09:2
14 the years the medical establishment, 09:2
15 particularly the physicians, have been very 09:2
16 vocal about the extremely conservative 09:2
17 payment procedures that NHIC uses. 09:2
18 Q. Do you know if that's been a problem in other 09:2
19 states? 09:2
20 A. No. 09:2
21 Q. You don't know one way or another or do you 09:2
22 know it's not been a problem? 09:2
23 A. I'm not advised. 09:2
24 Q. You just don't know? 09:2
25 A. Right. 09:2

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1 Q. So it's possible that other states have 09:
2 been -- their providers have been 09:
3 complaining about their fiscal agents and 09:
4 whether or not they're paying correctly? 09:
5 A. Possibly. 09:
6 Q. As being on the board, I believe you 09:
7 testified that you were on Medicaid 09:
8 director's commission. 09:
9 A. The Medicaid director's executive committee, 09:
10 yes. 09:
11 Q. Right. Have you ever heard other states 09:
12 complaining that -- or other states stating 09:
13 that there have been some issues as to 09:
14 whether or not their fiscal agent is paying 09:
15 properly or timely? 09:
16 A. I don't recall that issue came up. 09:
17 Q. Did you ever raise that issue with -- at your 09:
18 committee about that being a problem in 09:
19 Texas? 09:
20 A. No. 09:
21 Q. Okay. Now -- okay. Have you ever been 09:
22 critical of the Texas insurance arrangement 09:
23 with NHIC? 09:
24 A. I have been -- in the past I was concerned 09:
25 about the -- about whether or not the state 09:

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1 was getting benefit from using an insured 09:
2 arrangement. And as a result, the Lewin 09:
3 study was done in 1991, I think, that 09:
4 basically looked at the option of changing 09:
5 the way that our system was set up. 09:
6 Q. Okay. We'll get to the Lewin study in a 09:
7 second. Well, how were you critical of them, 09:
8 of the arrangement? 09:
9 A. I questioned whether we were getting benefit 09:
10 for the dollars that were being paid through 09:
11 a premium as opposed to straight bill paying. 09:
12 Q. Why? Why did you question that? 09:
13 A. As I recall, the concern that I had was that 09:
14 because patients had a difficult time seeing 09:
15 providers, I was not sure that the state was 09:
16 not paying premiums for services that were 09:
17 not getting provided. 09:
18 Q. And what did you do to alleviate that 09:
19 concern, if anything? 09:
20 A. The Lewin report. We have the Lewin study. 09:
21 Q. Okay. And that is one of the documents 09:
22 you're relying on for your testimony? Is 09:
23 that one of the documents listed? 09:
24 A. I don't see it. Oh, here it is. Yes. 09:
25 Q. And that would be No. 4, "Evaluation of 09:

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1 Medicaid Financing Options"? 09:3
2 A. Yes. 09:3
3 Q. I think that's supposed to be final report as 09:3
4 opposed to first report, Lewin? 09:3
5 A. Yes. 09:3
6 Q. Okay. What did the Lewin report say that 09:3
7 alleviated this concern you had? 09:3
8 A. Do you have it? 09:3
9 Q. Yes. 09:3
10 MR. HAY: Why don't we mark this as 09:3
11 Exhibit 6? 09:3
12 (Deposition Exhibit No. 6 09:3
13 (marked for identification?
14 A. We -- in the process of this report, we spent 09:3
15 a lot of time working and, in fact, we had 09:3
16 Mr. Moran who prepared this for us actually 09:3
17 advise us in the decision, given a number of 09:3
18 factors as to whether to convert at that time 09:3
19 to any other approach or to simply make 09:3
20 modifications in the existing contract to get 09:3
21 the best of both worlds. And what I 09:3
22 specifically recall in our work with Don was 09:3
23 that he indicated that it would -- that we 09:3
24 could make modifications in our plan which 09:3
25 would -- in our contract, which would 09:3

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1 basically take in the best of both worlds. 09:3
2 And that was the approach that we used, and 09:3
3 I'm afraid that's from information that's -- 09:3
4 that was subsequent to the filing of this 09:3
5 report. This was the first in a stage of 09:3
6 decision making that the state went through. 09:3
7 Q. Well, didn't, in fact, the report -- if you 09:3
8 look at ES.3, the first full paragraph on 09:3
9 that says, "Our analysis suggests that the 09:3
10 aggregate cost of the fiscal" -- "of the 09:3
11 fiscal agent option would be consistently 09:3
12 less than under a modified insurance 09:3
13 arrangement." Do you see that? 09:3
14 A. Yes. 09:3
15 Q. So isn't it, in fact, the conclusion of this 09:3
16 report that -- or the recommendation of this 09:3
17 report that a fiscal agent option would be 09:3
18 cheaper for the state? 09:3
19 A. At this time this was -- yeah, that was one 09:3
20 of the recommendations. It also says 09:3
21 "modifying the quota share system to 09:3
22 increase pricing accuracy and eliminate 09:3
23 incentives for premium inflation," which was 09:3
24 the -- one of the two things that they 09:3
25 recommend as the two main financing options, 09:3

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1 and that was the option we ended up taking. 09:
2 Q. Okay. But they gave you two options, modify 09:
3 the quota share system or convert to a fiscal 09:
4 agent arrangement. 09:
5 A. Right. 09:
6 Q. They recommended the conversion to a fiscal 09:
7 agent arrangement, correct? 09:
8 A. I don't think they actually recommend it. 09:
9 They say that their analysis suggested it. 09:
10 Q. Okay. 09:
11 A. But they don't -- I don't think they actually 09:
12 recommended it, because I remember he was 09:
13 hesitant to make an absolute recommendation. 09:
14 He was aware of the fact that there were lots 09:
15 of factors that go into a decision, and so 09:
16 that's why they did two options like that. 09:
17 Q. Wasn't one of the basic conclusions of this 09:
18 report is that year after year the premiums 09:
19 have been overestimated and they don't really 09:
20 know why that's the case, but the result of 09:
21 that is that there's really virtually no risk 09:
22 for the contractor? 09:
23 A. In retrospect, I think that's a conclusion 09:
24 that they drew in review of the program 09:
25 before, and that was the basis of making some 09:

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1 of the changes in the contract that we did 09:
2 make as a result. 09:
3 Q. And those changes are the changes in the 09:
4 contract that you referred to in '94? 09:
5 A. I believe it was '94. 09:
6 Q. Okay. Directing your attention to ES.2, the 09:
7 section that talks about incentives -- 09:
8 incentives and monitoring. 09:
9 A. Yes. 09:
10 Q. The first sentence talks -- says -- states 09:
11 that "While the contractor retains incentives 09:
12 for cost control, positive performance can 09:
13 most easily be guaranteed by ensuring that 09:
14 premiums are set high enough to ensure a 09:
15 maximum quota share gain, i.e. the tendency 09:
16 to overestimate premiums may be structurally 09:
17 intrinsic to the quota share arrangement." 09:
18 Do you agree or disagree with that? 09:
19 A. I don't necessarily agree with that, no. 09:
20 Q. Did you tell them that that's something you 09:
21 disagreed with? 09:
22 A. That was part of the ongoing discussion we 09:
23 had with them for a number of months after 09:
24 this report came out, which was the beginning 09:
25 of a process of deciding what to do. And the 09:

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1 reason is that the state sets those premiums 09:3
2 and has a very compelling interest in trying 09:3
3 to keep them as low as they possibly can. 09:3
4 It's a negotiated premium. And, for example, 09:3
5 at least during the years that I'm familiar 09:4
6 with in detail, we actually had our own 09:4
7 outside actuaries who would do numbers for us 09:4
8 who had absolutely no incentive to increase 09:4
9 the premium or do anything except give us the 09:4
10 best estimates of what each of our premiums 09:4
11 should be. 09:4
12 So while in the abstract a system 09:4
13 where all parties have that incentive to set 09:4
14 them high, I would agree with that. That's 09:4
15 not been the case in setting the premiums for 09:4
16 our contract. 09:4
17 Q. In terms of your last statement about having 09:4
18 an actuary involved, when did that -- that 09:4
19 was during your tenure? 09:4
20 A. Uh-huh. 09:4
21 Q. Did that happen prior to that, do you know? 09:4
22 A. I'm not sure. I believe so, but I'm not 09:4
23 sure. 09:4
24 Q. Okay. I take it you -- the statement that -- 09:4
25 the next sentence that says, "The contractor 09:4

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1 has, in fact, earned a maximum gain since the 09:4
2 inception of the program under the existing 09:4
3 rules." That I take it to mean means that 09:4
4 they got their maximum bonus above -- for the 09:4
5 premiums, for the excess premiums each year; 09:4
6 is that correct?
7 A. Yes. 09:4
8 Q. Okay. And you don't -- you can't -- you 09:4
9 don't dispute that, do you? 09:4
10 A. Not -- I have no -- 09:4
11 Q. Okay.
12 A. -- no independent knowledge. 09:4
13 Q. Okay. The last sentence in that paragraph 09:4
14 states that, "In addition, while the state 09:4
15 actively monitors overall claims payment lag, 09:4
16 there is no active monitoring of the detailed 09:4
17 mechanics of the payment process." 09:4
18 A. Okay. 09:4
19 Q. How do you reconcile your opinion that 09:4
20 there's close scrutiny with the statement 09:4
21 that there's no active monitoring of the 09:4
22 detailed mechanics of the payment process? 09:4
23 A. There's close scrutiny of the data that comes 09:4
24 from the payment process that judges whether 09:4
25 or not claims have been paid accurately. 09:4

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1 Whether or not it has anything to do with the 09:4
2 detailed mechanics, I can't speak to that. I 09:4
3 don't know the detailed mechanics. 09:4
4 Q. Well, actually, the beginning of the sentence 09:4
5 talks about monitoring overall claims payment 09:4
6 lag, which, and correct me if I'm wrong, I 09:4
7 took that to mean whether or not the payments 09:4
8 are getting timely made. 09:4
9 A. Yes. 09:4
10 Q. And -- but there's no monitoring of the 09:4
11 details of the mechanics of the payments 09:4
12 itself. 09:4
13 A. I can't speak to it. 09:4
14 Q. You don't know what they meant by that? 09:4
15 A. I don't know the details -- the detailed 09:4
16 mechanics. I don't know whether or not 09:4
17 that's a -- what the implications of that 09:4
18 might be. 09:4
19 Q. Is there anything else you're relying on this 09:4
20 evaluation, which is Exhibit 6, for -- with 09:4
21 respect to your testimony and opinions? 09:4
22 A. I don't think so. 09:4
23 Q. You mentioned one criticism you had of the 09:4
24 Texas insurance arrangement, and I don't want 09:4
25 to cut you off. Have there been any other 09:4

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1 criticisms that you've had of the insurance 09:4
2 arrangement? 09:4
3 A. If you're referring to something, maybe I can 09:4
4 respond, but I'm not recalling off the top of 09:4
5 my head. 09:4
6 Q. Okay. Was there a concern or criticism you 09:4
7 had about the reliability of the data that 09:4
8 you -- that Texas was getting from NHIC for 09:4
9 purposes of making projections and things of 09:4
10 that nature? 09:4
11 A. I don't recall. 09:4
12 Q. You don't recall that ever being in issue? 09:4
13 A. No. 09:4
14 (Deposition Exhibit No. 7 09:4
15 (marked for identification.
16 Q. I show you what's been marked as Exhibit 7 09:4
17 and ask if you've ever seen that document 09:4
18 before? 09:4
19 A. I don't recall it. 09:4
20 Q. Is it something that in your position in 09:4
21 Texas Medicaid at or around May of '91 would 09:4
22 normally come to your attention, these audit 09:4
23 reports regarding selective health care 09:4
24 services and NHIC activities? 09:4
25 A. Normally, no. 09:4

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1 Q. All right. 09:4
2 MR. HAY: Well, let me just for the 09:4
3 record -- what I've handed her as this 09:4
4 exhibit is titled "Texas Department of Human 09:4
5 Services Audit Report Operations Review, 09:4
6 Selective Health Care Services and NHIC 09:4
7 Activities, May 1" -- "May, 1991, Office of 09:4
8 Inspector General, Internal Audit." 09:4
9 Q. Well, if you don't specifically remember the 09:4
10 document, maybe you remember some of the 09:4
11 conclusions or discussions in it or issues 09:4
12 raised. On Page 1 under "Review Results," if 09:4
13 you read that first paragraph to yourself. 09:4
14 Ask you some questions about it. 09:4
15 A. Okay. 09:4
16 Q. Okay. In particular, the second sentence 09:4
17 there talks about, "Despite these efforts, 09:4
18 however, review findings indicated DHS is not 09:4
19 always as well-informed as it should be in 09:4
20 dealing with NHIC. Of particular concern is 09:4
21 NHIC's practice of furnishing DHS with data 09:4
22 concerning projected claims cost and RSR 09:4
23 balances which are frequently biased and 09:4
24 self-serving. This problem is exacerbated by 09:4
25 DHS staff' less than desirable knowledge of 09:4

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1 NHIC's financial activities and reporting 09:4
2 practices and their too frequent tendency to 09:4
3 accept NHIC-developed data at face value." 09:4
4 Do you recall a problem as to the 09:4
5 trustworth -- trustworthiness of the NH -- 09:4
6 the data that NHIC was providing DHS? 09:4
7 A. I'm drawing a blank on this. I'm trying to 09:4
8 remember the circumstances of this audit. 09:4
9 Q. So none of this is familiar with you? 09:4
10 A. I'm sorry. I'm not -- it's not bringing 09:4
11 anything up. 09:4
12 Q. Do you have any reason to doubt the 09:4
13 conclusion of this audit? 09:4
14 A. I have no reason. 09:4
15 Q. To doubt it? 09:4
16 A. Right. 09:4
17 Q. Did there come a time when you were a 09:4
18 proponent of an idea to dispense with the 09:4
19 game of overestimating or arguing over 09:4
20 forecasts and instead derive an accurate 09:4
21 caseload estimate and then establish a 09:4
22 Medicaid rainy day fund? 09:4
23 A. Yes. 09:4
24 Q. Okay. Why don't you tell us about that? 09:4
25 What -- what was -- first of all, did I 09:4

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1 describe what your proposal basically was? 09:4
2 A. Yes. 09:4
3 Q. Okay.
4 A. Well, I would like you to say it again just 09:4
5 to make sure I heard everything -- 09:4
6 Q. All right. Why don't you tell me what it was 09:4
7 rather than my words? Why don't we have it 09:4
8 in your words as to what -- what you were 09:4
9 proposing in terms of this rainy day Medicaid 09:4
10 fund? 09:4
11 A. The rainy day fund has been suggested a 09:4
12 number of times because of the nature of 09:4
13 Medicaid as a dynamic entitlement program. 09:4
14 It has been difficult to estimate for the 09:4
15 purposes of the state budget what the 09:4
16 experience would be for Medicaid, 09:4
17 particularly given the fact that the State of 09:4
18 Texas has a two-year budget process, which 09:4
19 means, in effect, that projections are made 09:4
20 up to 36 months out from the end of the 09:4
21 two-year fiscal cycle, the second fiscal year 09:4
22 of our two-year budget cycle. 09:4
23 And so there has been occasions 09:4
24 where in the budgeting process where an 09:4
25 appropriations bill is being developed in the 09:4

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1 odd-numbered years of the Texas legislative 09:4
2 session, that we have either -- that the 09:4
3 State of Texas has experienced either 09:4
4 overestimate or underestimate of what the 09:4
5 actual experience turns out to be. In other 09:4
6 words, we've come up short during a biennium 09:5
7 and we have not had to use all of the money 09:5
8 appropriated for the program. 09:5
9 And so one way to approach that 09:5
10 that has been suggested, and I still support 09:5
11 it, is to have the most conservative possible 09:5
12 estimate, which, you know, we try to do, and 09:5
13 then to have a second amount of money set 09:5
14 aside in the state budget which would be 09:5
15 available for contingencies should there be 09:5
16 unexpected growth in the program for whatever 09:5
17 reason, and that that fund would be activated 09:5
18 by virtue of a process with the Legislative 09:5
19 Budget Board.
20 Q. Okay. One thing I don't understand, you said 09:5
21 that, you know, have the most conservative 09:5
22 estimates, which you try to do. I mean, 09:5
23 isn't that the reason -- isn't the reason 09:5
24 that you were suggesting this rainy day fund 09:5
25 was that, in fact, what the state usually 09:5

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1 does is being pretty liberal and generous in 09:5
2 its estimates so that there wouldn't be a 09:5
3 shortfall, and you're suggesting that rather 09:5
4 than that, it should be conservative in its 09:5
5 estimates and have this backup fund, if you 09:5
6 will?
7 A. Well, there is a -- there are a lot of 09:5
8 factors that go into this, but to the extent 09:5
9 that there is any incentive for a state 09:5
10 person to round up, if you will, or to 09:5
11 overestimate, that this would help mitigate 09:5
12 that. I don't see that as being the primary 09:5
13 problem. 09:5
14 The primary problem is the 09:5
15 unpredictability of the program which is not 09:5
16 a function necessarily of determination of 09:5
17 a -- of a per person cost over, you know, a 09:5
18 24-month period. But that would, to whatever 09:5
19 extent it possibly could, provide a guarantee 09:5
20 to that estimate that we're not going to find 09:5
21 ourselves having to make cutbacks in the 09:5
22 program before the fiscal years are over, 09:5
23 which we've had to experience. 09:5
24 Q. Well, under the current circumstances, isn't 09:5
25 it your understanding that rather than being 09:5

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1 conservative in estimates, in most cases, the 09:5
2 estimates are usually pretty high just to 09:5
3 protect against the -- no one wants to be 09:5
4 responsible for having a shortfall? 09:5
5 A. We've had experience on both ends of that, 09:5
6 yes. I mean, we've had experience both 09:5
7 ways. They've been too much and they've been 09:5
8 too little. There are lots of factors that 09:5
9 go into estimating for Medicaid besides 09:5
10 premium rate. Caseload, for example. And 09:5
11 this last biennium we had a very large amount 09:5
12 of money that was turned back to the state 09:5
13 because the caseloads changed significantly. 09:5
14 That was not something that could be 09:5
15 predicted. So there are many factors that go 09:5
16 in. 09:5
17 Q. You mentioned a shortfall in estimates. Has 09:5
18 NH -- did NHIC bear the financial risk of any 09:5
19 of that -- any shortfall that's been 09:5
20 experienced? 09:5
21 A. I don't think that they did. 09:5
22 Q. And -- strike that. 09:5
23 Has -- did the state submit an 1115 09:5
24 Waiver to substantially alter the insurance 09:5
25 arrangement that -- has the state ever 09:5

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1 proposed -- strike that. 09:5
2 We'll just talk generally. 09:5
3 Has the -- has Medicaid considered 09:5
4 using a different arrangement as recently as 09:5
5 1995? 09:5
6 A. A different arrangement? 09:5
7 Q. Right, Medicaid insured arrangement. 09:5
8 A. Beyond the ongoing implementation of managed 09:5
9 care, I am not aware. 09:5
10 Q. Okay. Moving to the next paragraph of your 09:5
11 statement, which is there -- we can get rid 09:5
12 of some of those exhibits -- which is the 09:5
13 second full paragraph on that page, it says, 09:5
14 "Ms. Friedholm will testify that the timing 09:5
15 of the Texas Medicaid program's shift towards 09:5
16 managed care has been appropriate. 09:5
17 Ms. Friedholm will testify that the state 09:5
18 could not begin this transition until willing 09:5
19 managed care organizations and providers were 09:5
20 in place to service the managed care 09:5
21 population. She will further testify that 09:5
22 this requisite managed care infrastructure 09:5
23 had to be established before the Medicaid 09:5
24 program could receive federal waivers and 09:5
25 begin the transition to managed care." I 09:5

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1 take it that's your opinion? 09:
2 A. Yes. 09:
3 Q. Okay. What's the basis -- or strike that. 09:
4 What documents are you relying on 09:
5 to support that opinion? 09:
6 A. I'm not relying upon documents. 09:
7 Q. Okay. What are you relying on to support 09:
8 that opinion, what facts? 09:
9 A. My experience from the beginning in the move 09:
10 to managed care for the Medicaid population. 09:
11 Q. All right. What facts from your experience 09:
12 support that opinion? 09:
13 A. There was enormous amount of resistance on 09:
14 the part of the Texas medical establishment 09:
15 to moving to managed care. We put into 09:
16 legislation in 1991 a requirement that the 09:
17 Medicaid program establish pilot projects to 09:
18 test out different forms of managed care, at 09:
19 least one project. And as I have already 09:
20 described to you in the previous day's 09:
21 deposition, there was a delay in the state's 09:
22 ability to get managed care -- those two 09:
23 pilots started because of a lack of provider 09:
24 interest and participating in the program, 09:
25 both from a medical -- the physician 09:

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1 community, the hospital community in one 09:5
2 instance, as well as health maintenance 09:5
3 organizations. 09:5
4 And as a result, the managed care 09:5
5 projects came up in 1993 when they had 09:5
6 originally been intended to start in 1992. 09:5
7 It was -- and part of the issue has been the 09:
8 lack of -- lack of support or lack of 09:
9 interest on the part of the medical community 09:
10 and the HMO community. However, that has 09:
11 changed dramatically in the last couple of 09:
12 years. 09:
13 Q. As a matter of fact, I think your prior 09:
14 testimony was it changed dramatically in 09:
15 1994. 09:
16 A. Around 1994. 09:
17 Q. Okay.
18 A. I'm sorry. This is '97. Three years. 09:
19 Q. Any other facts that form the basis of this 09:
20 opinion? 09:
21 A. Just my general knowledge of the -- of 09:
22 Medicaid and the Medicaid in the health care 09:
23 environment in Texas. 09:
24 Q. Well, what does your general knowledge of 09:
25 Medicaid and the Medicare -- Medicaid 09:

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1 environment in Texas tell you that supports 09:
2 this opinion? 09:
3 A. That the general health care marketplace in 09:
4 Texas was shifting quickly from a fee for 09:
5 service to a managed care -- more widely 09:
6 based managed care option throughout the 09:
7 state, although there are still parts of the 09:
8 state where that's less true. That Medicaid 09:
9 was not perceived of as a program or its 09:
10 recipients considered to be desirable on the 09:
11 part of the medical establishment in too many 09:
12 instances. 09:
13 Q. Until '94? 09:
14 A. Until around 1994 when the competitive nature 09:
15 of the health care system made Medicaid 09:
16 patients look better as everyone was 10:
17 positioning for their market share. 10:
18 Q. And by the competitive nature of the health 10:
19 care, you're talking about the influx of HMOs 10:
20 in general in the private sector? 10:
21 A. Well, and the aggressive changes in the 10:
22 hospital systems in Texas that were becoming 10:
23 purchased by for-profit institutions. 10:
24 Q. Okay. Can you explain that to me? We 10:
25 haven't really talked about this -- that 10:

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1 fact. What do you mean by the aggressive 10:0
2 change in hospital systems in Texas? 10:0
3 A. The competition for patients among hospitals 10:0
4 was heightened as -- well, a number of 10:0
5 factors, one being that new hospitals were 10:0
6 being built that were for profit, that 10:0
7 not-for-profit institutions were being 10:0
8 purchased or managed by entities who were 10:0
9 focused predominantly on the bottom line, and 10:0
10 that altered the patient mix -- or it stood 10:0
11 as a potential for altering the patient mix 10:0
12 as they viewed Medicaid to be a relatively 10:0
13 important segment of the population. 10:0
14 Medicaid had grown to be a fairly large 10:0
15 segment of the uninsured population -- 10:0
16 Q. Who --
17 A. -- in the early '90s. 10:0
18 Q. I'm sorry. Who viewed the Medicaid 10:0
19 population as a -- as an important client to 10:0
20 be served, I guess in effect? Were you 10:0
21 talking about the for-profit hospitals? 10:0
22 A. I'm sorry. I'm kind of mixing, aren't I? 10:0
23 The -- well, yes. I mean, they came after 10:0
24 Medicaid and started aggressively marketing 10:0
25 and going after Medicaid patients. 10:0

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1 Q. And that, it's your testimony, took place 10:(
2 around 1994? 10:(
3 A. Yes. 10:(
4 Q. Okay. 10:(
5 A. There was a dramatic period of time in there 10:(
6 where, as Medicaid director, I went from a 10:(
7 position of trying to convince people that 10:(
8 they should want to take Medicaid or that 10:(
9 they ought to take Medicaid patients to a 10:(
10 position where I was overwhelmed by HMOs and 10:(
11 other medical providers who were suddenly 10:(
12 interested in it because its relative 10:(
13 position in the marketplace seemed to have 10:(
14 improved. 10:(
15 Q. Really. So you would describe it as being 10:(
16 overwhelmed subsequent to 1994 in terms of 10:(
17 the interest of providers in HMOs in managed 10:(
18 care for Medicaid? 10:(
19 A. It became a lot more -- there were a lot more 10:(
20 people interested in seeing how they could 10:(
21 participate in the program. Overwhelmed is 10:(
22 probably an overstatement, but it was a very 10:(
23 significant change. 10:(
24 Q. Let me ask you this: Are you a proponent of 10:(
25 Medicaid managed care? 10:(

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1 A. Yes. 10:
2 Q. Okay. What, in your view, are the advantages 10:
3 of Medicaid -- managed care for Medicaid? 10:
4 A. The predominate advantage -- advantages are 10:
5 an improved ability to have patients, 10:
6 establish a medical home with a provider so 10:
7 that they have someone to go see when they 10:
8 get sick, just like the rest of us like to 10:
9 have. And secondly, that that can lead to, 10:
10 at least in the short run, reductions in some 10:
11 of the expenditures for the program which -- 10:
12 which are not the most cost-effective 10:
13 expenditures, such as a use of an emergency 10:
14 room for something that could have been 10:
15 treated in a doctor's office. 10:
16 Q. Now, on the cost side, it's interesting. You 10:
17 testified previously that the Travis County 10:
18 HMOs are actually, as I understand it, paying 10:
19 your physicians more than what Medicaid was 10:
20 paying in terms of rates and -- 10:
21 A. For the primary care physicians. 10:
22 Q. For the primary care physicians. And yet the 10:
23 overall cost of that program was actually 10:
24 less -- 10:
25 A. Yes. 10:

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1 Q. -- than -- was a significant savings to the 10:
2 program? 10:
3 A. Uh-huh. 10:
4 Q. So it's possible to have higher rates and yet 10:
5 experience more significant savings? 10:
6 A. For primary care physicians, yes, which was 10:
7 my testimony. 10:
8 Q. The -- what other advantages as you see it to 10:
9 Medicaid managed care? You mentioned a 10:
10 patient having a medical home and reduction 10:
11 in certain expenditures, especially in areas 10:
12 like emergency rooms. Anything else? 10:
13 A. Those are the two primary ones that come to 10:
14 mind. 10:
15 Q. How about better preventive care? 10:
16 A. Yes. 10:
17 Q. Is that another advantage? 10:
18 A. It can be. 10:
19 Q. And would you agree that if there's better 10:
20 preventive care in the long run, the medical 10:
21 cost for the program should be decreased? 10:
22 A. Yes. 10:
23 Q. Let's talk about the reference here to the 10:
24 fact that Texas needed to have the 10:
25 infrastructure, as you use that term -- the 10:

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1 managed care infrastructure in place to 10:0
2 service the managed care population. What do 10:0
3 you need? What do you mean by 10:0
4 infrastructure? 10:0
5 A. That you had to have enough willing providers 10:0
6 to meet the requirements of a federal waiver 10:0
7 for managed care which would show that for a 10:0
8 given population base there were sufficient 10:0
9 and geographically distributed providers to 10:0
10 take the body of patients in the managed care 10:0
11 setting. And so that's what I was thinking 10:0
12 when I used that term. 10:0
13 Q. Okay. By the way, the infrastructure you're 10:0
14 referring to here, does that also include the 10:0
15 requisite number of state personnel to 10:0
16 oversee the program, or is that -- is that 10:0
17 really not a factor, that can just be added? 10:0
18 A. I'm sorry. Would you say that again? 10:0
19 Q. When you're talking about infrastructure, are 10:0
20 you just talking about provider base, which I 10:0
21 would assume means providers in HMOs, or are 10:0
22 you also talking about actually having the 10:0
23 state personnel there to manage the program? 10:0
24 A. Well, before one can receive federal waivers, 10:0
25 you're supposed to show that you have the 10:0

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1 capacity to manage the program and you must 10:0
2 answer questions to the federal government 10:0
3 about that. So that's true. 10:0
4 Q. Was that ever a problem? Was that one of the 10:0
5 reasons -- strike that. 10:0
6 Would you attribute one -- to one 10:0
7 of the reasons that Texas was not able to 10:0
8 implement managed care earlier is because it 10:0
9 didn't have the resources within the state 10:0
10 personnel, if you will, to manage the 10:0
11 program? 10:0
12 A. You're asking would I -- would I -- say that 10:0
13 again. Would I agree to it? 10:0
14 Q. Well, you've testified that the state didn't 10:0
15 have the infrastructure in place to implement 10:0
16 managed care earlier. And my question -- 10:0
17 what I'm trying to understand is, I 10:0
18 understand you're saying it didn't have the 10:0
19 HMOs and providers. Did they -- were they 10:0
20 lacking anything else in terms of 10:0
21 infrastructure? And I suggest to you that, 10:0
22 you know, one thing that you might consider 10:0
23 is, were they lacking the state personnel 10:0
24 available to manage it. And just let me know 10:0
25 yes or no. Did they have them or not? 10:0

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1 A. No, we did not have personnel with expertise 10:
2 in managed care to manage a Medicaid managed 10:
3 care. 10:
4 Q. Did you acquire that? 10:
5 A. We developed it. 10:
6 Q. You developed it. Is that something that 10:
7 could have been developed earlier if you 10:
8 tried to? 10:
9 A. Well, yes. I'm sure that it could have been 10:
10 developed if there was a sufficient move to 10:
11 try to take on managed care, which there was 10:
12 not. 10:
13 Q. And why wasn't there? 10:
14 A. For all of the reasons I've already stated to 10:
15 you about the lack of political support, the 10:
16 lack of physicians and other providers 10:
17 willing to take on Medicaid patients, a 10:
18 general lack in Texas of a base of private 10:
19 sector managed care. Texas was one of the 10:
20 slower states to bring managed care in, 10:
21 compared to other parts of the country. 10:
22 Q. How about compared to the other top 10 in 10:
23 terms of size and population states? Where 10:
24 did Texas rank in terms of its private 10:
25 managed care as of like 1990, do you know? 10:

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1 A. I have known that. I'm not recalling right 10:1
2 now a specific number. 10:1
3 Q. Was it the worst of the top 10? 10:1
4 A. I don't think we were the worst, but we were 10:1
5 among the last. 10:1
6 Q. Was there any study done as to how many 10:1
7 Medicaid providers at the time were also -- 10:1
8 were already in private HMO or also private 10:1
9 HMO providers? 10:1
10 A. I do not believe a study was done. 10:1
11 Q. How many HMOs do you need for this 10:1
12 infrastructure? 10:1
13 A. Well, it depends on the size of the Medicaid 10:1
14 population in the area that you're talking 10:1
15 about. 10:1
16 Q. Okay. Let's -- you know, as an example you 10:1
17 mentioned Harris County is starting up -- is 10:1
18 a contract that your client just was 10:1
19 successful in bidding. For something like 10:1
20 Harris County, how many HMOs would you need? 10:1
21 A. I think the state's estimate was five or six 10:1
22 HMOs. They originally estimated five HMOs 10:1
23 for that area and ended up with seven. 10:1
24 Q. Because 14 basically applied for the 10:1
25 contract, correct? 10:1

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1 A. Yes. 10:1
2 Q. Okay. In 1990, do you know how many HMOs 10:1
3 actually existed in Harris County? 10:1
4 A. No. It was one of the most developed areas 10:1
5 of the state, Harris was. 10:1
6 Q. Okay. So you're pretty confident that there 10:1
7 were at least five? 10:1
8 A. Yes. 10:1
9 Q. Okay. Why didn't Texas attempt to implement 10:1
10 managed care in Harris County, then, earlier, 10:1
11 earlier than this October? 10:1
12 A. I can't say specifically beyond a general 10:1
13 sense that it's a huge area and would be 10:1
14 difficult to implement because of the size of 10:1
15 the population there. Beyond that, I don't 10:1
16 know.
17 Q. Well, what's the difficulty? I mean, you 10:1
18 have the HMOs and providers. That's not the 10:1
19 issue, correct, in Harris County? 10:1
20 A. Well, maybe -- we do now, yes. 10:1
21 Q. Well, do you have any doubt that in 1990 you 10:1
22 would have had enough HMOs and providers? 10:1
23 A. I'm not sure that we would have had the right 10:1
24 mix of providers. I don't know. 10:1
25 Q. You don't know one way -- you don't know one 10:1

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1 way or another? 10:
2 A. No. 10:
3 Q. Okay. What's the other difficulty of 10:
4 establishing a managed care pilot program in 10:
5 Harris County other than -- well, this 10:
6 unknown fact which you don't know one way or 10:
7 another about whether or not there was enough 10:
8 providers? 10:
9 A. Again, the size. You know, it's over 300,000 10:
10 people. 10:
11 Q. So what's the significance of that? 10:
12 A. You have to get them signed up and 10:
13 enrolled -- educated, signed up, enrolled, 10:
14 and in many cases assigned to a project, and 10:
15 that's a very large project. 10:
16 Q. All right. But that has been successfully -- 10:
17 or is being accomplished as we speak, 10:
18 correct? 10:
19 A. We will see. 10:
20 Q. Okay. But what you're talking about there is 10:
21 resources? 10:
22 A. Yes. 10:
23 Q. Okay. Is there anything that would have 10:
24 prevented the State of Texas from having the 10:
25 resources back in 1990 to attempt to 10:

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1 implement managed care in Harris County? 10:1
2 A. There was not -- I cannot remember any 10:1
3 efforts or any interest in 1990 in doing 10:1
4 Medicaid managed care, period, whether it was 10:1
5 Harris or otherwise. 10:1
6 Q. In the State of Texas? 10:1
7 A. Uh-huh. 10:1
8 Q. When you say you can't remember any interest, 10:1
9 it certainly was discussed in the State of 10:1
10 Texas since the -- since the late '70s that 10:1
11 HMOs or managed care should be considered as 10:1
12 an option -- as an alternative way of 10:1
13 delivering services? 10:1
14 A. I don't know that to be true. 10:1
15 Q. When, to your recollection -- or when, to 10:1
16 your knowledge, was the first time that the 10:1
17 State of Texas considered or -- managed care 10:1
18 as an option for delivery of services? 10:1
19 A. 1991. 10:1
20 Q. And you're talking about in this pilot 10:1
21 program? 10:1
22 A. Uh-huh. 10:1
23 Q. Prior to 1991, to your knowledge, managed 10:1
24 care was never -- for Medicaid was never 10:1
25 discussed in the State of Texas as an option? 10:1

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1 A. I can't say it was never discussed. It did 10:1
2 not receive any high level amount of 10:1
3 discussion that would have made it a feasible 10:1
4 option. I mean, it's always theoretically 10:1
5 been an option. 10:1
6 Q. Well, let me ask you this: In 19 -- in 1990, 10:1
7 what were other states doing, the top 10 10:1
8 larger states? Did they all have managed 10:1
9 care projects in 1990? 10:1
10 A. I don't know about the top 10 states. A lot 10:1
11 of states had. 10:1
12 Q. And did you know what the experience of those 10:1
13 states were in terms of whether they were 10:1
14 saving dollars to the program? 10:1
15 A. I don't know. 10:1
16 Q. Did -- prior to or at or around 1991 when the 10:1
17 State of Texas was looking into managed care 10:1
18 in this pilot program, was any analysis done 10:1
19 of other state's experience? 10:1
20 A. Yes. 10:1
21 Q. Okay. And who did that? 10:1
22 A. The Legislative Budget Board, as I recall. 10:1
23 Q. And did they do some kind of report? 10:1
24 A. I'm going to have to correct that. It was -- 10:1
25 it was the -- oh, gosh. I think it actually 10:1

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1 came out as part of the performance -- Texas 10:1
2 Performance Review which was done in '91 with 10:1
3 borrowed staff from around the state, which 10:1
4 included LBB staff, Legislative Budget Board 10:1
5 staff. 10:1
6 Q. That's Breaking the Mold? Is that the one 10:1
7 you're referring to?
8 A. Whatever it was called. 10:1
9 Q. Okay.
10 A. The first one. 10:1
11 Q. The first one, okay. Were you familiar with 10:1
12 that report? 10:1
13 A. At one time I was. 10:1
14 Q. Did you have any involvement in the 10:1
15 preparation of it? 10:1
16 A. Not personally. 10:1
17 Q. Did -- were you ever asked to review or 10:1
18 comment on it? 10:1
19 A. I was asked to legislate it. I worked for 10:1
20 the lieutenant governor. And all of those 10:1
21 recommendations came to us. 10:1
22 Q. And your job was then to try and turn those 10:1
23 recommendations into law? 10:1
24 A. Yes. If my boss supported it. 10:1
25 Q. Okay. Maybe we'll go through some of the 10:1

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1 initiatives and see which ones he did and 10:
2 didn't, as you recall. 10:
3 Did you look into in terms of 10:
4 states -- other states' experience, did other 10:
5 states have the same issue that you've 10:
6 identified which is a lack of infrastructure 10:
7 when they began their managed care programs? 10:
8 A. I can't speak to that. 10:
9 Q. Do you know what other states have done to 10:
10 try and develop a managed care 10:
11 infrastructure, if anything? 10:
12 A. Many states have begun their managed care as 10:
13 voluntary projects, particularly relying on 10:
14 PCCM approaches. Those would be my comments. 10:
15 Q. Did you study or did Texas study the results 10:
16 of the PCCM approach to managed care in other 10:
17 states? 10:
18 A. I don't recall. 10:
19 Q. Do you know if the results of PCCM projects 10:
20 in other states was that it actually added 10:
21 cost to the program? 10:
22 A. I don't know. 10:
23 Q. Is that something that someone in Texas might 10:
24 have looked into, or do you know? 10:
25 A. It's possible. 10:

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1 Q. But you didn't do it? 10:2
2 A. No, I didn't personally. 10:2
3 Q. And no one ever reported to you what -- 10:2
4 A. They may have, I don't recall. 10:2
5 Q. Okay. Have you ever heard of a requirement 10:2
6 that some states might have been using that 10:2
7 required commercial HMOs to do some 10:2
8 percentage of Medicaid patients for some 10:2
9 brief period of time? 10:2
10 A. Yes, I vaguely remember that. 10:2
11 Q. Was that something Texas considered? 10:2
12 A. I don't know that we considered that. 10:2
13 Q. Do you know how successful that initiative 10:2
14 concerning having commercial HMOs do some 10:2
15 percentage of Medicaid patients was in other 10:2
16 states? 10:2
17 A. No. 10:2
18 Q. No? 10:2
19 A. No. 10:2
20 Q. Okay. Medicaid is the largest purchaser of 10:2
21 health care in Texas, correct? 10:2
22 A. I believe Medicare is. 10:2
23 Q. How many -- during your tenure as a Medicaid 10:2
24 director, what was the number of recipients, 10:2
25 approximately? 10:2

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1 A. I think in 1995 it was 2.5 million. 10:
2 Q. Were you aware that other states used 10:
3 Medicaid to develop managed care market 10:
4 penetration? 10:
5 A. No. I'm not aware of that. 10:
6 Q. That is, in effect, what happened in Texas, 10:
7 though, right? Once you started Medicaid 10:
8 managed care, you did get a fair number of 10:
9 new HMOs coming in to try and service that 10:
10 clientele, correct? 10:
11 A. Only after the first project. During the 10:
12 first project we didn't. 10:
13 Q. But after you began within a year, there was 10:
14 a dramatic increase in HMO penetration in 10:
15 Texas? 10:
16 A. Yes. I don't know about penetration. 10:
17 Interest in Medicaid, yes. 10:
18 Q. When you say you don't know about 10:
19 penetration, you don't know how many actually 10:
20 came to Texas? 10:
21 A. I don't know an exact number. 10:
22 Q. Okay. Don't you think that if the largest 10:
23 purchaser of health service or one of the 10:
24 largest purchasers of health service in the 10:
25 state was to start managed care, additional 10:

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1 providers would come into the state to deal 10:2
2 with those -- to deal with that market? 10:2
3 A. I don't know. 10:2
4 Q. Well, certainly one of your clients has done 10:2
5 that, right? 10:2
6 A. Which provider -- I don't know which 10:2
7 providers you're referring to. 10:2
8 Q. I mean talking about HMOs. 10:2
9 A. Yes. That has been our experience. 10:2
10 Q. Do you know of other states that had similar 10:2
11 experience? 10:2
12 A. I can't speak to that specifically. 10:2
13 MR. HART: Whenever you get to a 10:2
14 breaking point, let's take a break. 10:2
15 MR. HAY: We can break now. 10:2
16 THE VIDEOGRAPHER: Stand by, 10:2
17 please. The time is 10:24 a.m. We're going 10:2
18 off the record. 10:2
19 (RECESS) 10:2
20 (Deposition Exhibit No. 8 10:3
21 (marked for identification
22 THE VIDEOGRAPHER: Stand by. The 10:4
23 time is 10:42 a.m. We're on the record. 10:4
24 Q. Okay. One of the reasons for the timing in 10:4
25 the implementation of managed care in Texas 10:4

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1 that you mentioned before was the 10:4
2 political -- or the politics of it. Can you 10:4
3 kind of describe for us what you meant by 10:4
4 that? 10:4
5 A. The -- well, generally speaking, there had 10:4
6 been a very large increase in the program. 10:4
7 It had gone from being a relatively smaller 10:4
8 program to one that had, as we've already 10:4
9 commented, close to 2 million people, over 2 10:4
10 million people. And so the dynamics, the 10:4
11 importance of the program suddenly became a 10:4
12 lot more well-known and it became more of a 10:4
13 concern to the state leadership, particularly 10:4
14 because of the budget implications. 10:4
15 And so there began to be more 10:4
16 interest in finding ways to further curtail 10:4
17 costs of the program, if possible. And it 10:4
18 was within that context as well as a desire 10:4
19 to try to improve the patient-physician 10:4
20 relationship and get better preventive care 10:4
21 that we moved -- the state began to move 10:4
22 towards managed care in the early 1990s, and 10:4
23 that's when the issue of managed care, to my 10:4
24 memory, began to be discussed as a viable 10:4
25 option for -- and a feasible option for 10:4

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1 Medicaid. 10:4
2 Q. Well -- 10:4
3 A. It was at that point that it began to receive 10:4
4 attention. 10:4
5 Q. Okay. Well, my question actually was, you 10:4
6 had stated that there was political 10:4
7 impediments to managed care getting started, 10:4
8 and I was trying to understand what you meant 10:4
9 by that. You had indicated that the 10:4
10 infrastructure wasn't there and you also 10:4
11 mentioned that the politics or the political 10:4
12 situation made it difficult for managed care, 10:4
13 and I was trying to -- that was the nature of 10:4
14 my question. And what I'd like to understand 10:4
15 is what did you mean by the politics that 10:4
16 made it difficult or -- to implement managed 10:4
17 care until when the State of Texas did? 10:4
18 A. Well, there was not a lot -- I think when 10:4
19 I -- I was referring to those items as well, 10:4
20 but there was not a lot of support for 10:4
21 capitated HMO managed care among the provider 10:4
22 community and that still remains a problem in 10:4
23 some areas. So I think that's the reference 10:4
24 I'm making, that the medical establishment 10:4
25 wasn't a proponent of managed care. 10:4

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1 Q. Okay. And how did that -- how did that 10:4
2 translate into political pressure? 10:4
3 A. Their unwillingness to want to go along with 10:4
4 it. I mean, it's a provider community. 10:4
5 That's who you have to have as part of the 10:4
6 Medicaid program, and they expressed their 10:4
7 lack of support for it. The state is not 10:4
8 likely to -- or not as likely to try to force 10:4
9 it until -- until they feel like there's a 10:4
10 way to do so successfully. You have to have 10:4
11 providers participate and want to participate 10:4
12 and support the program if it's going to 10:4
13 work. 10:4
14 Q. So in '93 when you started it, they didn't 10:4
15 support the program, but in '94, they then 10:4
16 turned around and did. Is that what your 10:4
17 testimony is? 10:4
18 A. We started to see larger numbers -- large 10:4
19 numbers of providers and HMOs willing to 10:4
20 discuss with the state moving to managed 10:4
21 care, and I think providers were also getting 10:4
22 used to it in terms of the private side. At 10:4
23 least, that's what they said to us. 10:4
24 Q. Let me show you what's been marked as Exhibit 10:4
25 8, and ask if you've ever seen that document, 10:4

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1 which I think is a -- is actually a 10:
2 collection of two documents. 10:
3 A. Yes. 10:
4 Q. Can you tell us for the record what that -- 10:
5 at least the first page of the document is? 10:
6 A. Well, it's a notification in the Texas 10:
7 Register of the state's interest in moving 10:
8 forward with managed care in other parts of 10:
9 the State of Texas. 10:
10 Q. Okay. Have you seen the second document? 10:
11 And I understand it's the -- actually it's 10:
12 just the first couple of pages of a 10:
13 document. I apologize for that. It's 10:
14 actually a very thick document, but -- 10:
15 A. This is not -- I'm not sure what this is. 10:
16 Q. Okay. 10:
17 A. Oh, I do know what this is. 10:
18 Q. Okay. What is this -- those pages? 10:
19 A. These pages are a listing of the responses 10:
20 that different provider groups sent in 10:
21 response to the Register publication. That's 10:
22 the first part of this exhibit. 10:
23 Q. Okay. So Exhibit 8, the first page is the 10:
24 kind of request for proposals or whatever 10:
25 from two providers? 10:

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1 A. Uh-huh. 10:4
2 Q. And this -- the next three pages is -- is the 10:4
3 beginning part of the responses which kind of 10:4
4 lists the people who responded? 10:4
5 A. Uh-huh. 10:4
6 Q. Is that correct? 10:4
7 A. Yes. That is correct. 10:4
8 Q. Okay. Do you recall getting responses from 10:4
9 about 57 providers to this or -- to this 10:4
10 request? Does that sound about right? 10:4
11 A. I don't recall that number. 10:4
12 Q. Would you -- do you recall the amount of -- 10:4
13 and I'm not talking about the -- in general 10:4
14 terms, not specific number, the -- how would 10:4
15 you describe the response to the request that 10:4
16 was in the Texas Register about future 10:4
17 managed care programs? 10:4
18 A. I was pleased by the interest as exhibited by 10:4
19 the range of entities that responded as 10:4
20 listed here. Not all of these are entities 10:4
21 that can be a managed care system, but they 10:4
22 indicated their interest in having a role in 10:4
23 the Texas Medicaid program as they -- as we 10:4
24 expanded managed care. 10:4
25 Q. Well, if they couldn't be -- what kind of 10:4

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1 role would they be talking about aside from 10:
2 the HMO type people? 10:
3 A. Some of these are providers. 10:
4 Q. And providers. So you got a pretty -- you 10:
5 got a very good response from providers and 10:
6 HMOs in response to this Texas Register 10:
7 request. Is that a fair statement? 10:
8 A. We got a -- what did you say? 10:
9 Q. A very good response in terms of numbers of 10:
10 people interested. 10:
11 A. We were pleased, yes. 10:
12 Q. Okay. Did the state respond to each of these 10:
13 either proposals or indications of interest 10:
14 by each of these providers? 10:
15 A. Respond in what sense? 10:
16 Q. In any sense. What did the state do? Did 10:
17 they contact these providers or what did they 10:
18 do, having received these statements of 10:
19 interest by these providers and HMOs? 10:
20 A. They -- we proceeded to develop plans for the 10:
21 next sites -- well, actually, hearings were 10:
22 held in different locations. I don't know if 10:
23 any kind of written response was ever made to 10:
24 these individual groups that provided 10:
25 something. I'm not aware if they did or 10:

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1 not. And public hearings were held in a 10:
2 number of locations and plans were made to 10:
3 proceed with more managed care sites. 10:
4 Q. Okay. So what happened after this was, after 10:
5 you got this good response was, you went 10:
6 forward with managed care plans, but you 10:
7 don't necessarily know whether or not the 10:
8 State of Texas in any way contacted these 10:
9 particular entities that had contacted you 10:
10 about managed care? 10:
11 A. The state developed a request for proposal 10:
12 which was made available to all of these 10:
13 entities, and they were notified when there 10:
14 were public hearings in the areas where they 10:
15 were located and were encouraged to 10:
16 participate and to respond to the RFP. 10:
17 Q. Was any analysis done of the -- whatever 10:
18 information was sent to you by these I guess 10:
19 57 different entities or study or summary or 10:
20 anything of that nature? 10:
21 A. Yes, I think there was a summary. 10:
22 Q. And who was that performed by? 10:
23 A. Linda Wertz. 10:
24 Q. Do you recall seeing that document? 10:
25 A. I don't recall the document. I remember that 10:

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1 I met with Linda and I think other members of 10:5
2 her staff to get a summary of it -- a verbal 10:5
3 summary of it. 10:5
4 MR. HAY: Sure. Can we go off the 10:5
5 record for a second? 10:5
6 THE VIDEOGRAPHER: Stand by, 10:5
7 please. The time is 10:52 a.m. This is the 10:5
8 end of Tape 1. Going off the record. 10:5
9 (OFF THE RECORD) 10:5
10 THE VIDEOGRAPHER: Stand by, 10:5
11 please. The time is 10:54 a.m. We're on the 10:5
12 record. This is Tape 2 of the deposition of 10:5
13 Ms. Friedholm. 10:5
14 Q. Okay. We were talking about the summary that 10:5
15 Linda Wertz prepared. What was her position 10:5
16 at the time? 10:5
17 A. She was the -- I don't know that I can recall 10:5
18 the specific title, but she was head of the 10:5
19 managed care bureau. 10:5
20 Q. Okay. Did she make any recommendations along 10:5
21 with that report that you recall? 10:5
22 A. No. Not that I recall. 10:5
23 Q. Are you familiar with Senate Bill 10 which 10:5
24 was passed by the 74th Legislature? 10:5
25 A. Yes. 10:5

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1 Q. Okay. Did that bill authorize the 10:
2 restructuring of the Texas Medicaid statewide 10:
3 to incorporate managed care? 10:
4 A. Yes. 10:
5 Q. Okay. Is that the first time that the 10:
6 legislature had authorized or approved 10:
7 expanding managed care statewide? 10:
8 A. Yes. 10:
9 Q. Okay. Did you have a role in either 10:
10 preparing or advocating for that bill? 10:
11 A. Yes. 10:
12 Q. What was your role? 10:
13 A. I was Medicaid director and had overseen the 10:
14 development of those recommendations which 10:
15 became the body of Senate Bill 10. 10:
16 Q. Was an 1115 Waiver drafted in response to 10:
17 that legislation? 10:
18 A. Yes. 10:
19 Q. Okay. What was the purpose of the waiver? 10:
20 A. The waiver's purpose was to convert local 10:
21 dollars spent on indigent care for 10:
22 individuals into Medicaid, the state match 10:
23 for Medicaid so that we could draw federal 10:
24 funds for that and expand -- and 10:
25 commensurately expand Medicaid eligibility to 10:

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1 cover people who otherwise previously would 10:5
2 not have been covered by Medicaid and perhaps 10:5
3 access those locally-funded services, and to 10:5
4 do that through -- and at the same time 10:5
5 implement such a plan along with the 10:5
6 implementation of Medicaid managed care 10:5
7 projects across the state. 10:5
8 Q. Were you involved in preparing that waiver? 10:5
9 A. Yes. I oversaw the preparation of the 10:5
10 waiver. 10:5
11 Q. Was the State of Texas prepared to take 10:5
12 managed care statewide at that point? 10:5
13 A. At that point? 10:5
14 Q. Right. 10:5
15 A. You mean -- I'm sorry. I'm not sure. 10:5
16 Q. When you submitted the waiver. 10:5
17 A. We laid out plans for doing so if the waiver 10:5
18 had been approved. 10:5
19 Q. What -- just -- I'm sorry. 10:5
20 A. Go ahead. 10:5
21 Q. What was the date that the waiver was 10:5
22 submitted -- 10:5
23 A. August 31st -- 10:5
24 Q. -- approximately? 10:5
25 A. August 31st, 1995. 10:5

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1 Q. How long did you expect statewide 10:
2 implementation to take place? 10:
3 A. I don't recall. 10:
4 Q. Was there an adequate infrastructure as of 10:
5 1995 for statewide implementation of managed 10:
6 care? 10:
7 A. I believe so. 10:
8 Q. Did you consider taking managed care 10:
9 statewide with the existing Medicaid 10:
10 population, and by that I mean without the 10:
11 new additional eligibles that became part of 10:
12 the waiver? 10:
13 A. Yes. And the state is doing that. 10:
14 Q. I'm talking about as of August of '95 when 10:
15 you submitted the waiver. Was that -- was 10:
16 one of the options that you were considering 10:
17 was just instead of attempting to add the 10:
18 eligibles in the waiver, just going forward 10:
19 with the statewide managed care with the 10:
20 existing Medicaid population? 10:
21 A. That was the plan, to proceed with 10:
22 implementation of managed care with the 10:
23 regular, if you will, Medicaid population in 10:
24 anticipation of the waiver being approved, or 10:
25 if the waiver was not approved, that the 10:

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1 state would have continued to do that and has 10:5
2 continued to do that. 10:5
3 Q. Okay. Did -- were questions received from 10:5
4 HCFA concerning the waiver? 10:5
5 A. Yes, I believe so. 10:5
6 Q. Did the State of Texas respond to them? 10:5
7 A. Eventually. 10:5
8 Q. Was there some lengthy period of time between 10:5
9 the time that those questions were received 10:5
10 and when they were responded to? 10:5
11 A. I believe there was. 10:5
12 Q. Okay. In submitting the waiver, does the -- 10:5
13 does HCFA have a certain amount of time 10:5
14 either to approve, deny or ask questions? 10:5
15 A. Yes. 10:5
16 Q. And how long was that? 10:5
17 A. I don't remember anymore. 10:5
18 Q. 60 days, 90 days, that -- 10:5
19 A. Ball park. 10:5
20 Q. Ball park. And I take it that HCFA response 10:5
21 to the waiver was to ask certain questions 10:5
22 within that time period from when you 10:5
23 submitted the waiver? 10:5
24 A. I believe so. 10:5
25 Q. All right. And then how long after HCFA 11:0

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1 submitted the questions did the State of 11:0
2 Texas provide answers? 11:0
3 A. I don't know. 11:0
4 Q. Do you have an approximation? 11:0
5 A. No. 11:0
6 Q. Is it 60 days or is it months or -- 11:0
7 A. It was several months, but I don't know how 11:0
8 long.
9 Q. Okay. Were you involved in that process of 11:0
10 responding to those questions? 11:0
11 A. No. 11:0
12 Q. You had left by then? 11:0
13 A. Yes. 11:0
14 Q. Okay. So I take it you weren't involved in 11:0
15 preparing a revised version of the waiver? 11:0
16 A. No. 11:0
17 Q. Has the waiver been revised? 11:0
18 A. Yes. 11:0
19 Q. Do you know how it's been revised? 11:0
20 A. It was scaled back to only cover children, 11:0
21 and that's all I know about it. 11:0
22 Q. When you say only cover children, you're 11:0
23 talking about -- 11:0
24 A. In the expanded population. 11:0
25 Q. -- in the expanded population. Okay. For 11:0

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1 the -- I'm going to ask you some questions 11:0
2 about the individual managed care programs 11:0
3 for the different counties. And for the HMO 11:0
4 projects, which I guess is Travis and I guess 11:0
5 let's first talk about our universe. There's 11:0
6 Travis, there's tri-city, there's Bexar, 11:0
7 Lubbock and what other? 11:0
8 A. Tarrant. 11:0
9 Q. Tarrant, okay. That has been -- that are 11:0
10 actually -- been bid out and contracts 11:0
11 awarded. 11:0
12 A. Yes. 11:0
13 Q. And Harris, and that's always been bid out -- 11:0
14 A. Yes.
15 Q. -- and contract awarded? 11:0
16 A. Yes. 11:0
17 Q. Any others? 11:0
18 A. No. 11:0
19 Q. Okay. Of those we know that tri-cities is 11:0
20 the PCCM? 11:0
21 A. You mean the tri-county? 11:0
22 Q. Tri-County. 11:0
23 A. Yes. 11:0
24 Q. Okay. And Travis is HMO and what else, 11:0
25 physician -- prepaid? 11:0

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1 A. The first two-year -- the first project, 11:(
2 which was a two-year project, was one HMO and 11:(
3 one partially capitated health plan, which is 11:(
4 called PHP. The state rebid it for last fall 11:(
5 and started the second iteration of managed 11:(
6 care in this area with I believe four HMOs 11:(
7 only. 11:
8 Q. Okay. The PHP, you said? 11:
9 A. Yes. 11:
10 Q. Can you describe what that is? 11:
11 A. It was a -- it is a provision allowed under 11:
12 federal Medicaid law for the state to 11:
13 designate a group as partially capitated for 11:
14 the purposes of managed care and they can 11:
15 serve as the primary care -- their doctors 11:(
16 can serve as the primary care physicians and 11:(
17 they receive some capitation for certain 11:(
18 services that they have within their system, 11:
19 and then they are not held responsible for 11:
20 the other costs that might be incurred under 11:
21 the Medicaid program which continue to be 11:(
22 paid, I believe, on a fee-for-service basis. 11:(
23 Q. Okay. And that only lasted for two years? 11:(
24 A. That's my -- yes. 11:(
25 Q. Okay. Is that present in any other managed 11:(

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1 care program, pilot program or county 11:
2 program? 11:
3 A. Not in Texas. 11:
4 Q. Not in Texas? Was it involved in other 11:
5 states or utilized in other states? 11:
6 A. It is an option for other states to use and 11:
7 it is used some, but I'm not familiar with-- 11:
8 with extent of that. 11:
9 Q. Okay. Do you -- was there any study done as 11:
10 to the results of its use in other states 11:
11 before using it in Travis County? 11:
12 A. Not that I recall. 11:
13 Q. Why was it included? 11:
14 A. Because, really, for two reasons. One was 11:
15 under the federal Medicaid program, you have 11:
16 to offer an individual at least two choices 11:
17 of provider, and we only had one HMO who 11:
18 would participate in the first project. And 11:
19 so we were facing a situation in which we 11:
20 could -- would have to offer a choice of 11:
21 going into an HMO or staying in a regular 11:
22 fee-for-service system. And it appeared that 11:
23 that would be what we would have to do, which 11:
24 would make it not as good a project as we had 11:
25 wanted it to be in terms of managed care. 11:

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1 And we were approached by a East Austin 11:0
2 clinic system called Vista which has long 11:0
3 been a major provider to Medicaid and other 11:0
4 indigents in East Austin. They wanted to 11:0
5 participate. In fact, they wanted to become 11:0
6 an HMO to participate. There was not time 11:0
7 for them to qualify to do that, and so we 11:0
8 worked out a partially capitated health plan 11:0
9 which gave us a second choice so that we 11:0
10 didn't have to continue to offer fee for 11:0
11 service. And so that was how the pre -- the 11:0
12 partially capitated health plan was brought 11:0
13 into the system. 11:0
14 Q. Is Vista -- did Vista eventually become an 11:0
15 HMO? 11:0
16 A. I'm not sure. 11:0
17 Q. Are they participating in the second 11:0
18 iteration of the Travis County project? 11:0
19 A. No. 11:0
20 Q. They're not? 11:0
21 A. I don't believe so. They may be as a 11:0
22 provider. 11:0
23 Q. A provider, but not as a -- they're not one 11:0
24 of the four HMOs? 11:0
25 A. No. 11:0

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1 Q. Okay. But as I understand your testimony, it 11:(
2 was just a matter -- in some ways it was a 11:(
3 matter of timing. If there was more time, 11:(
4 they could have become an HMO and 11:(
5 participated in the initial Travis County 11:(
6 project that way? 11:(
7 A. They came to us in the summer before a 11:(
8 September 1 start date, and there was not 11:(
9 time to become an HMO unless we were to 11:(
10 further delay the project. We had already 11:(
11 spent a year more than we had hoped to have 11:(
12 to in finding HMO in getting set up to start 11:(
13 the project, and so we moved forward with 11:(
14 that. And they indicated that they would 11:(
15 pursue becoming an HMO, and if they achieved 11:(
16 that, we would relook at the situation. 11:(
17 Q. Has any analysis been done as to what the 11:(
18 results from this PHP system was, whether -- 11:(
19 you know, in terms of cost savings, in terms 11:(
20 of emergency room utilization, the same types 11:(
21 of factors that we discussed previously? 11:(
22 A. I believe so. 11:(
23 Q. Okay. And do you recall what the results 11:(
24 were? 11:(
25 A. I believe the results were that it was more 11:(

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1 expensive. 11:(
2 Q. Than the HMO or than the current fee for 11:(
3 service? 11:(
4 A. Than fee for service. 11:(
5 Q. Okay. The -- while we're talking about -- 11:(
6 while we're talking about Travis County, 11:(
7 the -- you said two years later they rebid 11:(
8 and got four HMOs? 11:(
9 A. Uh-huh. 11:(
10 Q. And that's --
11 A. Selected four HMOs. 11:(
12 Q. And selected four HMOs. Okay. You 11:(
13 anticipated my question. How many -- do you 11:(
14 know how many bids they got? 11:(
15 A. No. 11:(
16 Q. So you don't know how many other HMOs had bid 11:(
17 for that project? 11:(
18 A. I'm not certain. 11:(
19 Q. When was that project -- when was the bids 11:(
20 due on that project? Putting it into 11:(
21 context, it was '93. It ended, I assume -- 11:(
22 that first project ended in '95? 11:(
23 A. I don't recall the specific due date for that 11:(
24 project. 11:(
25 Q. Did it begin in 1995? 11:(

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1 A. No. 11:(
2 Q. Okay. So sometime in 1996? 11:(
3 A. Wait a minute. This is 1997. 11:(
4 Q. Right. 11:(
5 A. It started October 1 of '96 as a -- as the 11:(
6 four HMOs. 11:(
7 Q. Okay. How were the capitation rates 11:(
8 determined for those four HMO -- for the 11:(
9 Travis County project? 11:(
10 A. The people bid rates that they would -- the 11:(
11 state established a base rate, and if -- if 11:
12 the companies wanted to -- if the HMOs wanted 11:
13 to bid below that, they got benefits or they 11:
14 got bonus -- bonus points for that in their 11:
15 request for proposal, which was judged on a 11:(
16 point basis. 11:(
17 Q. Do you know how many of the four HMOs in 11:(
18 Travis County bid below the base rate? 11:(
19 A. I don't know that. 11:(
20 Q. Do you know any of the details of the bids 11:(
21 for the Travis County -- 11:(
22 A. No, I don't.
23 Q. -- four HMOs? 11:(
24 A. No. 11:(
25 Q. Why did the state provide a base rate? Why 11:

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1 not just open it up for bids without any kind 11:
2 of base capitation rate? 11:
3 A. There was concern that an HMO may -- might 11:
4 low ball in order to gain a market share of 11:
5 Medicaid and then not be able to meet the 11:
6 requirements. And in discussions with other 11:
7 states, it was concluded that setting the 11:
8 base rate would give protection that you did 11:
9 not have companies that merely lowballed in 11:
10 order to get into the marketplace. 11:
11 Q. Well, what other states did you discuss that 11:
12 with? 11:
13 A. I didn't. 11:
14 Q. Okay. Did Texas discuss that with? 11:
15 A. I can't answer that question. 11:
16 Q. Who would -- who would know that? 11:
17 A. Linda Wertz. 11:
18 Q. And any other reasons why the state had a 11:
19 base capitation rate for that? 11:
20 A. Not that I know of. 11:
21 Q. Is that -- in determining capitation rates 11:
22 for all the Medicare managed care programs in 11:
23 Texas, is that the way it's been done in each 11:
24 instance? 11:
25 A. Do you mean Medicaid? 11:

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1 Q. Medicaid, excuse me, yeah. With the base 11:1
2 rate, capitation rate and then bidding. 11:1
3 A. Since the first one, yes. That's my -- yes, 11:1
4 that's -- they've set a different one for 11:1
5 each of the areas and had providers bid -- 11:1
6 HMOs bid. 11:1
7 Q. Right. They being the -- 11:1
8 A. -- the state. 11:1
9 Q. The state has set a base rate and had 11:1
10 providers -- HMOs bid for each of -- for each 11:1
11 of the different areas as well? 11:1
12 A. Yes. 11:1
13 Q. Okay. And what did you do in the original 11:1
14 Travis County project? 11:1
15 A. Well, we only had one HMO and we -- the 11:1
16 state individual -- the state staff developed 11:1
17 a target rate and then we negotiated that 11:1
18 rate with PCA, which was the HMO who was in 11:1
19 the project. 11:1
20 Q. How was the target rate established, 11:1
21 capitation rate established by the state? 11:1
22 A. I can't say. 11:1
23 Q. Who was involved in that? 11:1
24 A. Steven Scarborough. 11:1
25 Q. Okay. Okay. In terms of Bexar County, is 11:1

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1 it? 11:1
2 A. Yes. 11:1
3 Q. Can you describe that managed care program? 11:1
4 A. Bexar County has a combination program of 11:1
5 PCCM and capitated managed care HMOs. 11:1
6 Q. How many HMOs? 11:1
7 A. Three. 11:1
8 Q. And do you know how many HMOs bid for that 11:1
9 program? 11:1
10 A. Approximately 10. 11:1
11 Q. And the capitation rate was again set the 11:1
12 same way that the states set a base rate and 11:1
13 then allowed bids either -- that could be 11:1
14 below that rate? 11:1
15 A. Yes. 11:1
16 Q. Okay. Now, you said it also included a PCCM 11:1
17 portion? 11:1
18 A. Yes. 11:1
19 Q. Why? 11:1
20 A. The provider community in Bexar County -- and 11:1
21 by that I mean the Bexar County medical 11:1
22 society -- maintain that the -- that there 11:1
23 was a large and sufficient provider base in 11:1
24 Bexar County that had been seeing patients 11:1
25 and that did not want to move into an HMO. 11:1

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1 capitated system for Medicaid, that they 11:
2 wanted to have an opportunity to show that 11:
3 they could do just as good or better at 11:
4 management of patient care and patients' 11:
5 costs and that the -- that it would be a 11:
6 perfect opportunity to test out head to head 11:
7 managed care capitated HMOs versus PCCM. 11:
8 Q. The state knew that the history of PCCM was 11:
9 that the rates actually were higher than fee 11:
10 for services? 11:
11 A. I didn't know that at that time. We hadn't 11:
12 gotten any data from the first project yet. 11:
13 Q. What about from other states? Have you 11:
14 gotten any data from other states as to how 11:
15 other states were doing with PCCM? 11:
16 A. I don't recall that. 11:
17 Q. Okay. Did the 10 HMOs that bid for -- for 11:
18 the Bexar County project indicate that they 11:
19 didn't have sufficient providers to service 11:
20 the population? 11:
21 A. No. 11:
22 Q. How many PCCMs bid? 11:
23 A. There is only one PCCM in the area. 11:
24 Q. In the area? 11:
25 A. I mean, it's -- it's a network of individuals 11:

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1 that sign up for it. 11:
2 Q. Okay. But it's not run through a particular 11:
3 company? Who puts the network together? 11:
4 A. NHIC currently, about to become Maximus. 11:
5 Q. Okay. And that's what we spoke before about 11:
6 getting -- NHIC removing its obligation to 11:
7 sign up people for either the HMO or the 11:
8 PCCM. 11:
9 A. Right. 11:
10 Q. Okay. Do you know the results of the Bexar 11:
11 County project? 11:
12 A. Do I know the results? 11:
13 Q. Results in terms of, well, if this was the 11:
14 perfect opportunity to compare PCCM and HMOs 11:
15 in a variety of different ways, what have the 11:
16 results been? 11:
17 A. It's been 10 months. I don't know that there 11:
18 have been any results yet. 11:
19 Q. But you don't know if there's cost -- what, 11:
20 if any, cost savings have been achieved by 11:
21 either the HMOs or the PCCMs? 11:
22 A. I'm not -- I'm not advised. I don't know. 11:
23 Q. Do you know if there's been a problem in that 11:
24 program with enrollees kind of defaulting 11:
25 into the PCCM program or not actually 11:

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1 selecting between the HMOs and the -- and the 11:
2 PCCM and therefore being put into one group 11:
3 or another? 11:
4 A. I'm not aware of that. 11:
5 Q. Have you heard about any problems or 11:
6 difficulties with the Bexar County project? 11:
7 A. The enrollment -- initial enrollment there 11:
8 were problems. 11:
9 Q. What were the problems with the enrollment? 11:
10 A. My understanding was that there were -- the 11:
11 instances I heard of were ones where an 11:
12 individual was assigned to a primary care 11:
13 provider in either system, HMO or PCCM, who 11:
14 was not appropriate to play the role of 11:
15 primary care provider. For example, a child 11:
16 being assigned to an OB-GYN -- 11:
17 Q. Okay.
18 A. -- or a mom being assigned to a pediatrician 11:
19 for her care. Those were the examples that I 11:
20 had heard of in discussions about 11:
21 implementation. 11:
22 Q. Any other implementation problems that you're 11:
23 aware of? 11:
24 A. Do you mean with regard to enrollment or -- 11:
25 Q. Just getting the projects up and going, 11:

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1 the -- Bexar. I'm just talking about the 11:1
2 Bexar project now, Bexar County. 11:1
3 A. I'm not quite familiar -- I'm not familiar 11:1
4 with others. 11:1
5 Q. Okay. The Lubbock project, can you describe 11:1
6 for me what that is, and by that I mean is 11:1
7 that an HMO or PCCM? 11:1
8 A. Lubbock is a PCCM and HMO mix like Bexar 11:1
9 County.
10 Q. How many HMOs? 11:1
11 A. I'm not sure I know. 11:1
12 Q. Do you know how many bid? 11:1
13 A. Not in Lubbock. I don't know. 11:1
14 Q. And do you know -- have there been 11:1
15 implementation problems in Lubbock? 11:1
16 A. I haven't heard. 11:1
17 Q. Let me ask you kind of a different question 11:1
18 about these various counties that we've been 11:1
19 talking to. What is the -- what has been the 11:1
20 population that they've been serving, the 11:1
21 Medicaid population? Is this -- you know, is 11:1
22 this one portion of the population or is it 11:1
23 the entire Medicaid population are the -- 11:1
24 A. It is the non-SSI population, is a simple way 11:2
25 to say that. 11:2

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1 Q. Okay. 11:2
2 A. Moms and kids. 11:2
3 Q. Moms and kids. It is moms and kids. It's 11:2
4 not the disabled and elderly? 11:2
5 A. Correct. 11:2
6 Q. And other SSI? 11:2
7 A. Well, that's who is SSI. 11:2
8 Q. Okay. And is -- that's true for each of the 11:2
9 Travis, tri-county, Bexar and Lubbock? 11:2
10 A. Yes. 11:2
11 Q. Is that also true for Harris? 11:2
12 A. No. 11:2
13 Q. Harris is different. Okay. And I keep 11:2
14 forgetting the last one you mentioned. 11:2
15 A. I'm sorry. What were the ones you just ran 11:2
16 through? I -- 11:2
17 Q. Travis, tri-county, Bexar, Lubbock, Harris. 11:2
18 A. Tarrant. 11:2
19 Q. Tarrant. Okay. Is that -- is Tarrant also a 11:2
20 moms and kids population? 11:2
21 A. Yes. 11:2
22 Q. All right. Do you know how many -- is 11:2
23 Tarrant also both PCCM and HMO? 11:2
24 A. No. 11:2
25 Q. It's just HMO? 11:2

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1 A. Yes. 11:2
2 Q. Okay. How many HMOs? 11:2
3 A. Four. 11:2
4 Q. And do you know how many bid for the project? 11:2
5 A. I don't remember the number. 11:2
6 Q. Okay. And this one hasn't started yet, 11:2
7 right? This is another -- 11:2
8 A. Started in October of last year. 11:2
9 Q. Oh, October of last year. Okay. Any 11:2
10 problems with implementation that you -- that 11:2
11 you've heard or are aware of? 11:2
12 A. The -- to a lesser degree, the same kind of 11:2
13 issue of assignment of the wrong kind of 11:2
14 primary care provider in some cases, as I've 11:2
15 already given you an example. 11:2
16 Q. Okay. And then the last one is Harris 11:2
17 County?
18 A. Yes. 11:2
19 Q. And that is scheduled to start this October? 11:2
20 A. It may be November, but this fall. 11:2
21 Q. This fall. Okay. And you said that is not 11:2
22 just -- is that -- what's the population? 11:2
23 A. The population, it has a two-part -- it's a 11:2
24 two-part project. And one -- the first part 11:2
25 is mandatory enrollment, as all of them have 11:2

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1 been, but mandatory enrollment for all 11:2
2 Medicaid individuals. And there is a second 11:2
3 project which is managed care for the 11:2
4 long-term care side, so that it is a -- an 11:2
5 all-encompassing project that includes 11:2
6 individuals who need long-term care or who 11:2
7 were dually Medicare and Medicaid eligible. 11:2
8 Q. This is actually a project in which you -- 11:2
9 one of your clients was successful in bidding 11:2
10 for. 11:2
11 A. One of my clients was successful in bidding 11:2
12 for both of those. 11:2
13 Q. Okay. Both of them being both parts or -- 11:2
14 A. Both parts. 11:2
15 Q. Okay. That was my next question. Were they 11:2
16 bid separately -- as separate parts? 11:2
17 A. Yes. 11:2
18 Q. Okay. 11:2
19 A. Generally. 11:2
20 Q. Let's talk about the mandatory enrollment for 11:2
21 all Medicaid first. How many HMOs does that 11:2
22 involve? 11:2
23 A. Seven. 11:2
24 Q. And I think my recollection is you told me 11:2
25 that there were 14 bids for that? 11:2

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1 A. I believe that's right. 11:2
2 Q. Okay. And this again was -- the capitation 11:2
3 rate was a base rate -- a base rate was set 11:2
4 by the state? 11:2
5 A. Yes. 11:2
6 Q. And the managed care for the long-term care 11:2
7 side, is that HMOs as well? 11:2
8 A. Yes. 11:2
9 Q. And how many HMOs are involved in that? 11:2
10 A. Three. 11:2
11 Q. One of which is your client? 11:2
12 A. Yes. 11:2
13 Q. Okay. And how many bid for that portion of 11:2
14 it? 11:2
15 A. I don't remember. 11:2
16 Q. How does it work, the long-term care side? 11:2
17 A. The three providers had to develop networks 11:2
18 that included the full array of -- of 11:2
19 providers that participate in the long-term 11:2
20 care side and negotiate contracts with all of 11:2
21 those different providers and meet a very 11:2
22 expensive set of criteria that the state 11:2
23 developed in the RFA, in the request for 11:2
24 proposal, RFP, with regard to case 11:2
25 coordination, the coordination of a dually 11:2

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1 eligible person's Medicaid and Medicare, if 11:
2 that person is either in Medicare fee for 11:
3 service or if that person is in Medicare 11:
4 HMO. And I'm not sure -- I don't remember 11:
5 the details of the financing and how 11:
6 extensively that's capitated. It is 11:
7 capitated to a large extent, but I don't 11:
8 remember if it's completely capitated for 11:
9 that population. 11:
10 Q. Was there any estimates that you're aware of 11:
11 of savings to the program for -- that are 11:
12 expected for this Harris County long-term 11:
13 care side? 11:
14 A. I'm not familiar with them. They would have 11:
15 to be part of the waiver, but I'm not 11:
16 familiar with them. 11:
17 Q. So that kind of information would be included 11:
18 in the waiver? 11:
19 A. I believe so. 11:
20 Q. We've had difficulty getting the waiver from 11:
21 the state. That's the reason I ask. 11:
22 A. I have not seen it. 11:
23 Q. The -- and would that also be true for the 11:
24 all Medicaid part of the Harris County, that 11:
25 there would be estimates of expected savings? 11:

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1 A. Yes. 11:
2 Q. Do you recall whether there was -- without 11:
3 knowing what the number was, that on both 11:
4 parts there were expected savings to the 11:
5 program? 11:
6 A. With the nonlong-term care project? 11:
7 Q. Right. 11:
8 A. Yes, there are expected savings. I don't 11:
9 recall anything about the -- in fact, I don't 11:
10 know that I've ever known on the long-term 11:
11 care side. 11:
12 Q. Okay. Now, I won't ask you every county 11:
13 going forward and what is planned for that, 11:
14 other than the general question of the 11:
15 populations that are intended to be 11:
16 included. Are they all going to be all 11:
17 Medicaid or are they going to go back to 11:
18 mothers and kids or both, if you know? 11:
19 A. The state's plan has been, if possible, to 11:
20 have all groups in by statewide 11:
21 implementation, by the time it's all 11:
22 statewide. 11:
23 Q. And what --
24 A. I think that's contingent upon this project, 11:
25 you know, working and yielding information 11:

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1 and educating them about how to actually 11:2
2 manage this type of project, this population. 11:2
3 Q. Educating who how to manage this type of 11:2
4 population? 11:2
5 A. Providers and -- the HMOs and the state. 11:2
6 Q. You really don't know that until you start 11:2
7 doing the project then and seeing what 11:2
8 problems come up and then dealing with them? 11:2
9 A. There is a lot of concern on the part of 11:2
10 particularly the disabled and elderly 11:2
11 populations that -- that this is fairly 11:2
12 experimental, not a lot of experience around 11:
13 the country in it, and that we need to be 11:
14 cautious and move forward if it's 11:
15 successful. And so that's what I'm 11:2
16 reflecting when I say the state's intent is 11:2
17 to go forward, but there's less certainty 11:2
18 about that than on the regular Medicaid side, 11:2
19 the moms and kids side. 11:2
20 Q. Why did the state go forward with the moms 11:2
21 and kids as opposed to all of the Medicaid -- 11:2
22 and I'm not talking about the long-term 11:2
23 care. I'm just talking about the regular -- 11:2
24 the acute care, if you will, Medicaid side? 11:2
25 A. You mean the disabled? 11:2

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1 Q. Yes. 11:2
2 A. They all get acute care if they need it. 11:2
3 Q. Right. 11:2
4 A. The -- there was concern that we didn't have 11:2
5 a lot of experience and that providers did 11:2
6 not have experience on the private side with 11:2
7 capitated management of a disabled 11:2
8 individual. Most states have pursued this 11:2
9 two-part approach of starting with moms and 11:1
10 kids and building in -- to some degree, some 11:1
11 states have built in and included SSI, the 11:1
12 disabled and aged population. 11:1
13 Q. From the start, you mean? Some have done it 11:1
14 from the start? 11:1
15 A. I don't know who has done it from the start 11:3
16 or not, but they add them in later. And 11:3
17 then -- I just lost my train of thought. I'm 11:3
18 sorry.
19 Q. I'm sorry. I didn't mean to interrupt and do 11:3
20 that. 11:3
21 A. Okay. The question was? 11:3
22 Q. Why didn't the State of Texas include the 11:3
23 disabled from the outset in their managed 11:3
24 care? 11:3
25 A. Well, and so the decision was made and -- I 11:3

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1 need to kind of correct that statement. We 11:3
2 have since the second round of the four -- 11:3
3 the now five sites that include the first two 11:3
4 original sites plus the three others, Bexar, 11:3
5 Tarrant and Lubbock, SSI individuals are 11:3
6 allowed to voluntarily enroll. So it's not 11:3
7 that they are excluded, but they are not 11:3
8 mandated into the system yet. Now, in Harris 11:3
9 County they're being mandated in for the 11:3
10 first time. So it's a -- it's a cautionary 11:3
11 approach to dealing with a more complex set 11:3
12 of medical needs and services available to 11:3
13 them. 11:3
14 Q. Has the -- have other states included the 11:3
15 disabled in their managed care, mandatory 11:3
16 managed care programs? 11:3
17 A. A few. 11:3
18 Q. Do you recall any study that the State of 11:3
19 Texas did as to the problems and advantages 11:3
20 of doing that? 11:3
21 A. Yes. The state has been very active in 11:3
22 keeping up with what's been going on even 11:3
23 subsequent to when we did our first study 11:3
24 which was contained in "Prescription for 11:3
25 Change," the document we've referenced the 11:3

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1 last time. 11:3
2 Q. Right. 11:3
3 A. And it looks into being able to move to 11:3
4 managed care for the SSI-type population as 11:3
5 well as a more -- the more comprehensive 11:
6 long-term care approach. 11:
7 Q. Have other states had problems that Texas has 11:
8 been able to identify with respect to moving 11:
9 into the SSI population in managed care? 11:
10 A. Yes, there has been some -- some problems. 11:
11 For example, Oregon had to delay their 11:
12 implementation of bringing SSI in for a 11:
13 number of months. There are systems issues, 11:
14 there are provider issues, there are 11:
15 capitation issues. It's a more complicated 11:
16 approach. 11:
17 Q. Well, I assume it's more complicated because, 11:
18 if nothing else, you're just adding to the 11:
19 types of treatments, and I mean, obviously 11:
20 kids and young mothers have different 11:
21 problems than the disabled. So in that 11:
22 sense, it's different and it's more, so it's 11:
23 more complicated. But what I'm trying to 11:
24 understand is, you know, in negotiating 11:
25 capitation rates at all, wouldn't it be to 11:

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1 the state's advantage to be able to include 11:3
2 the entire population because the disabled 11:3
3 treatment is actually pretty expensive and 11:3
4 rather than just giving the easier young 11:3
5 mothers and kids, which are less expensive, 11:3
6 you would -- there's an advantage, isn't 11:3
7 there, to including the more expensive 11:
8 treatment? 11:
9 A. I think that's why the state's moving in that 11:
10 direction. 11:
11 Q. And -- but the State -- but other states have 11:
12 had experience in that that Texas can -- or 11:
13 could have utilized, so I guess what I'm 11:
14 trying to understand is why didn't they do it 11:
15 from the start? 11:
16 A. At the time that we were putting together the 11:
17 first plans, there really weren't states that 11:
18 I can recall that had any or much 11:
19 experience. It was considered to be an 11:
20 merging area, and there were numbers of 11:
21 conferences and there continue to be numbers 11:
22 of conferences where states participate in 11:
23 looking at the issues of mandatorily bringing 11:
24 in SSI and requiring them to be in managed 11:
25 care. 11:

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1 Q. Are pharmacy services covered by managed 11:
2 care? 11:
3 A. No. 11:
4 Q. And why not? 11:
5 A. Because the pharmaceutical industry was able 11:
6 to get legislation passed prohibiting the 11:
7 state from including it. 11:
8 Q. So it's more political than anything else in 11:
9 terms of reasons why it didn't happen, it's 11:
10 not included in the managed care? 11:
11 A. The legislature prohibited the state from 11:
12 doing that. 11:
13 Q. Did the state want to include pharmacy? 11:
14 A. Yes. 11:
15 Q. Why did the state want to include pharmacy in 11:
16 the managed care program? 11:
17 A. We believed that it should be part of the 11:
18 overall capitation rate that an individual is 11:
19 paid in order to manage care and that savings 11:
20 could be -- could be gained as a result of 11:
21 that. It made sense to put it in as part of 11:
22 the mix because prescriptions are important 11:
23 in medical care. 11:
24 Q. Was there also an elimination of the -- and I 11:
25 think you referred to this limitation 11:

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1 before -- the three-prescription-a-month 11:3
2 pharmacy? Has that been eliminated with 11:3
3 respect to people who are involved in managed 11:3
4 care? 11:3
5 A. Yes. 11:3
6 Q. What's the -- 11:3
7 A. As I recall. 11:3
8 Q. What's the rationale for that? 11:3
9 A. That if an individual has a medical home with 11:3
10 a provider who is responsible for their total 11:3
11 care, that they can better -- that treatment 11:3
12 for those individuals would be potentially 11:3
13 improved in terms of being able to keep them 11:3
14 from getting sicker. 11:3
15 Q. Was your department in favor of that -- the 11:3
16 elimination of that restriction? 11:3
17 A. Oh, yes. 11:3
18 Q. Even though the pharmacy is going to be paid 11:3
19 on a fee-for-service basis? 11:3
20 A. Yes. 11:3
21 Q. Okay. Isn't there a risk that in managing 11:3
22 the care, the person in charge of the care 11:3
23 who was going to get paid on a 11:3
24 fee-for-service basis would be more likely to 11:3
25 do a maintenance program based on drugs, 11:3

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1 rather than actually treating someone for it 11:
2 which he's getting paid on a capitation 11:
3 basis? Isn't that a risk? 11:
4 A. I'm sorry. A maintenance program? 11:
5 Q. Well, rather than treat someone with -- on 11:
6 drugs -- with drugs on prescriptions rather 11:
7 than actually identifying the problem and 11:
8 treating them for something that they're 11:
9 capitated for, you have the same person who 11:
10 is getting paid on a capitated basis and 11:
11 getting paid on a fee-for-services basis, 11:
12 isn't there a realistic possibility that the 11:
13 tendency would be to prescribe more drugs for 11:
14 the treatment rather than, you know, doing 11:
15 other procedures that would be covered by the 11:
16 capitation rate? Was that a concern? 11:
17 A. Yes. 11:
18 Q. Okay. And it was a concern, but despite that 11:
19 concern, your department was in favor of 11:
20 allowing the limitation to be removed, the 11:
21 limitation on a number of prescriptions? 11:
22 A. Yes. 11:
23 Q. Why is that? 11:
24 A. We believed that the patients would be 11:
25 getting better care. 11:

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1 Q. What did your -- what did your department do, 11:3
2 if anything, to alleviate the concern about 11:3
3 the -- the possibility that the care would be 11:3
4 more drug -- more related to the drugs 11:3
5 than -- than under the capitation? 11:3
6 A. I'm not sure that I can point to anything. 11:3
7 Q. Is that one of the reasons why you wanted 11:3
8 the -- you being your department wanted the 11:3
9 pharmacy program to be included within the 11:3
10 managed care so that that way you're -- 11:3
11 you're ensuring that the best care is given 11:3
12 to the patient regardless of the method of 11:3
13 compensation because it's the same method of 11:3
14 compensation? 11:3
15 A. Yes. 11:3
16 Q. Okay. But you didn't win that battle? 11:3
17 A. Correct. 11:3
18 Q. Did you -- do you have any estimates as to 11:3
19 the cost, possible cost savings to the 11:3
20 program if the pharmacy portion of the 11:3
21 program was included in managed care? 11:3
22 A. I don't have any estimates of that. 11:3
23 MR. HAY: Mark that as the next
24 exhibit, please.
25 (Deposition Exhibit No. 9 11:4

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1 (marked for identification.
2 MR. HART: How long do you think
3 you're going to be on those two exhibits?
4 MR. HAY: I don't know. 15
5 minutes, you know.
6 MR. HART: Do you need to break for 11:4
7 lunch now? 11:4
8 THE WITNESS: No, let's -- let's go 11:4
9 for 15 minutes. 11:4
10 MR. HAY: Actually, I have a
11 shortened version, so I may be -- what
12 exhibit number is this?
13 THE REPORTER: That was 9.
14 THE WITNESS: This is Part 2. Is
15 that Part 1? No, that's Part 2 also.
16 Q. Let me show you what's now been marked as 11:4
17 Exhibit 9, and ask you to take a look at 11:4
18 that. 11:4
19 A. Okay. 11:4
20 Q. And if you could, identify it for the record 11:4
21 for us. 11:4
22 A. This is a second set of briefing materials 11:4
23 for the hearing on Medicaid options scheduled 11:4
24 for May 31st-June 1st presented to the 11:4
25 Honorable Judith Zaffirini, Chair of the 11:4

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1 Senate Health and Human Services Committee by 11:4
2 myself. 11:4
3 Q. When you say by yourself, you were talking -- 11:4
4 you prepared these materials for --
5 A. No, submitted by me. 11:4
6 Q. Oh, okay.
7 A. Sorry. Signed by me. 11:4
8 Q. Okay. Did you oversee the preparation of 11:4
9 these materials to be sent to her? 11:4
10 A. Yes. 11:4
11 Q. Okay. Actually, if you will, I just wanted 11:4
12 to ask a couple of questions about them in 11:4
13 general. First of all, what was the reason 11:4
14 for preparing these materials? 11:4
15 A. I had been charged -- Senator Zaffirini had 11:4
16 been charged along with me to develop by the 11:4
17 lieutenant governor of Texas, who gives these 11:4
18 types of directives, to develop the -- 11:4
19 develop options for changing Medicaid for the 11:4
20 purpose of controlling the cost of the 11:4
21 program as much as possible. 11:4
22 Q. Okay. And this document that you -- that was 11:4
23 prepared under your -- was this document 11:4
24 prepared under your direction? 11:4
25 A. Yes. 11:4

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1 Q. Okay. And this was for purposes of upcoming 11:4
2 hearings on the issue? 11:4
3 A. Yes. 11:4
4 Q. Okay. Let me direct your attention to the 11:4
5 portion of the document that -- and what I'll 11:4
6 do is I'll give you the document production 11:4
7 number, which is this number down here at the 11:4
8 bottom. HHSC -- or H -- excuse me. HHS 11:4
9 0007136, which is under -- which is under 11:4
10 Section 3, "Texas Options Under Current Law." 11:4
11 A. Okay. 11:4
12 Q. All right. 11:4
13 A. Does that -- does that say "Managed Care" at 11:4
14 the top? 11:4
15 Q. "Managed Care Options for Texas." 11:4
16 A. All right.
17 Q. Okay. And this talks about three major 11:4
18 options for fundamentally restructuring the 11:4
19 Medicaid basic health system, health service 11:4
20 delivery system? 11:4
21 A. Yes. 11:4
22 Q. Okay. And then it talks about -- and I'm 11:4
23 reading really the first paragraph, second 11:4
24 sentence -- "These options are not 11:4
25 necessarily mutually exclusive. For example, 11:4

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1 Texas could apply for a 1915b Waiver while 11:
2 pursuing an 1115 Waiver." 11:
3 A. Yes. 11:
4 Q. All right. What's a 1915b Waiver? 11:
5 A. Managed care waiver. 11:
6 Q. Okay. And what's an 1115? 11:
7 A. An 1115 Waiver is required if the state is 11:
8 going to make fundamental changes in the 11:
9 program such as expanding eligibility. 11:
10 Q. And as I understand it, the State of Texas 11:
11 did pursue the 1115 Waiver? 11:
12 A. The state pursued both. 11:
13 Q. Both. Okay. So it did do both at the same 11:
14 time?
15 A. The waivers were not submitted at the same 11:
16 time, but the state was proceeding with 11:
17 developing managed care projects at the same 11:
18 time.
19 Q. Okay. Can you briefly describe for me what 11:
20 the three options are that you're talking 11:
21 about? And these are the options for 11:
22 implementing managed care in Texas that you 11:
23 were considering as of May of '94. 11:
24 A. Okay. The first option was the phase-in of a 11:
25 statewide managed care system for Medicaid, 11:

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1 all families and children. The phase-in 11:4
2 would begin in metropolitan areas and be 11:4
3 expanded to rural counties subsequently. It 11:4
4 included the prospect of bringing in elderly 11:4
5 and disabled individuals. 11:4
6 Q. That was a part -- that was possible to add 11:4
7 the SSI people as part of the first option? 11:4
8 A. Yes. Some areas would pilot test including 11:4
9 other Medicare eligibles such as elderly and 11:4
10 disabled, and that each metropolitan area 11:4
11 would be phased in on a four-month 11:4
12 implementation schedule. 11:4
13 Q. Okay. 11:4
14 A. So that's basically it. 11:4
15 Q. First -- that's Option A? 11:4
16 A. Option A. 11:4
17 Q. Okay. 11:4
18 A. Option B would be to pursue an 1115 Waiver 11:4
19 along similar lines to Oregon, although 11:4
20 combining several things, but the primary of 11:4
21 which would be to reconsider the federal 11:4
22 mandatory options and go through a 11:4
23 prioritization process of those benefits 11:4
24 similar to what Oregon had done, which is 11:4
25 referred to as a rationing program. And in 11:4

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1 addition to that, include several other ideas 11:4
2 for altering the Medicaid program such as 11:4
3 implementing copays within federal 11:4
4 requirements, capitating and including 11:4
5 long-term care services such as in Arizona, 11:4
6 extending eligibility periods of individuals 11:4
7 from six to 12 months, and those were the 11:4
8 major aspects of that option, Option B. 11:4
9 Option C was to pursue a different 11:4
10 1115 Waiver, to similar to one that Tennessee 11:4
11 had received in 19 -- I think '94, '95, and 11:4
12 to -- in doing so, we would pool the local 11:4
13 health care dollars that are currently being 11:4
14 used by hospital districts and/or counties 11:4
15 and other state entities into a expanded 11:4
16 program, but that expansion would be done 11:4
17 through managed care providers and we could 11:4
18 increase coverage for individuals. And 11:4
19 that's Option C. 11:4
20 Q. Okay. Which, if any, of the options were 11:4
21 implemented? 11:4
22 A. Senate Bill 10 proceeded with actually bits 11:4
23 and pieces of each of these. 11:4
24 Q. Okay. 11:4
25 A. I would say the base approach in Senate Bill 11:4

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1 10 was Option C, which was to pursue an 1115 11:4
2 Waiver which pooled existing state and local 11:4
3 resources to expand coverage to uninsured 11:4
4 working Texans through Medicaid and through a 11:4
5 managed care system for that. It also 11:4
6 included copays, telephone triage and 11:4
7 extended eligibility period. I'm not sure 11:4
8 that we actually ended up including that in 11:4
9 the waiver, but we were directed to try to 11:4
10 include that in the waiver and there were 11:4
11 cost problems with it. 11:4
12 Q. Who directed you -- 11:4
13 A. Senate Bill 10. Senate Bill 10 directed the 11:4
14 Medicaid program to pursue an 1115 Waiver 11:4
15 with all kinds of different items in it. 11:4
16 Q. Okay. But -- okay. The extended 11:4
17 eligibility, you're talking about different 11:4
18 groups to be added? 11:4
19 A. Yes, but I was referring -- excuse me -- 11:4
20 specifically to Page 2, there is a bullet for 11:4
21 extended eligibility period of six months -- 11:4
22 Q. Okay.
23 A. -- or 12 months, and we were directed to try 11:4
24 to implement that. We could not make the 11:4
25 dollars work on it. It was going to be too 11:4

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1 expensive. 11:4
2 Q. Okay. Why were you directed to implement 11:4
3 that? 11:4
4 A. There was a desire to, if possible, have 11:5
5 people on the program for longer periods of 11:5
6 time for those who cycle on and off the 11:5
7 program, thought it would be helpful to the 11:
8 managed care system. 11:
9 Q. Is that not a requirement of the program, 11:
10 six-month eligibility? 11:
11 A. No. 11:
12 Q. No? Okay. 11:
13 A. Month to month. 11:
14 Q. Month to -- I mean, in the managed care 11:
15 program as it -- as it has developed? 11:
16 A. No, it is not. 11:
17 Q. Okay. So that provision was dropped from the 11:
18 managed care programs? 11:
19 A. Texas has not ever had that. There was -- I 11:
20 take that back. It's not quite true. The -- 11:
21 in Austin for the PCA project, there was a 11:
22 six-month -- initial six-month eligibility 11:
23 level for individuals who chose PCA, which 11:
24 was a federally-qualified -- 11:
25 federally-qualified HMO, which under federal 11:

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1 Medicaid rules you could do. And that has 11:
2 not been continued, to my knowledge. 11:
3 Q. In any other -- any other county? 11:
4 A. No, and I don't think it's being continued in 11:
5 Travis either. 11:
6 Q. Okay. Now, looking at Option A for the 11:
7 moment. 11:
8 A. Option which? I'm sorry. 11:
9 Q. A. This is -- this is talking about phasing 11:
10 into the major metropolitan areas initially 11:
11 and then covering all families -- all 11:
12 families and children, and then as I 11:
13 understand it, expanding out from the 11:
14 metropolitan areas to the surrounding rural 11:
15 areas. 11:
16 A. Yes. 11:
17 Q. Okay. Now, this talks about a possible start 11:
18 date of January 1, 1995. 11:
19 A. Yes. 11:
20 Q. Did that occur? 11:
21 A. No. 11:
22 Q. Okay. Why not? 11:
23 A. The legislature wanted to legislate and they 11:
24 didn't come back into session until January 11:
25 of 1995. 11:

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1 Q. And it talks about "Potentially TDH could 11:5
2 implement" -- I'm reading down in the next 11:5
3 sentence -- "could implement concurrently in 11:5
4 multiple regions in sufficient" -- "if 11:5
5 sufficient administrative resources were made 11:5
6 available"? 11:5
7 A. Yes. 11:5
8 Q. So your view at this time was that you 11:5
9 actually could do this implementation -- this 11:5
10 statewide managed care implementation 11:5
11 starting in January of 1995 and implementing 11:5
12 concurrently in multiple regions? 11:5
13 A. On a -- well, to be clear, this recommends 11:5
14 that it would be phased in, but that it could 11:5
15 be phased in in more than one place at a 11:5
16 time, depending on what resources were 11:5
17 available, yes. 11:5
18 Q. And the resources you're talking about are 11:5
19 basically state management personnel, 11:5
20 correct? 11:5
21 A. Yes. 11:5
22 Q. Okay. We're not talking about HMOs or 11:5
23 anything like that.
24 A. Not at this point, no. 11:5
25 Q. Okay. As a matter of fact, the next 11:5

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1 paragraph says, "It is believed that the high 11:5
2 concentration of Medicaid clients in the 11:5
3 urban areas, coupled with the existence of 11:5
4 HMOs and other private and public managed 11:5
5 health delivery systems would allow the 11:5
6 implementation of managed care to be the" -- 11:5
7 "to the greatest number of its clients in 11:5
8 the least amount of time." 11:5
9 A. Correct. 11:5
10 Q. So at that point in time, in terms of on a 11:5
11 statewide basis, you thought you had the 11:5
12 sufficient infrastructure of HMOs and 11:
13 providers? 11:
14 A. I can't say that absolutely across the entire 11:5
15 state, but that that would -- that we would 11:5
16 be phasing in as quickly as possible, 11:5
17 starting with urban areas, and then bringing 11:5
18 in subsequent rural areas surrounding as 11:5
19 quickly as possible. 11:5
20 Q. Right. And how long would it take to 11:5
21 complete the statewide under this option? 11:5
22 A. I don't recall. Does it say in there? 11:5
23 Q. Well, let me -- on Page 2, it doesn't state 11:5
24 what the full amount is, but it does say -- 11:5
25 and I'll read the last paragraph of Option A, 11:5

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1 "If started in" -- I assume that means 11:5
2 fiscal year 1995 -- "the phase-in of projects 11:5
3 would accelerate in fiscal year '96-'97 11:5
4 adding approximately 300,000 more people to 11:5
5 managed care each year. Net total savings 11:5
6 would be estimated" -- "would be an estimated 11:5
7 28 million in fiscal year '96 and 45 million 11:5
8 in fiscal year '97 when a total of 790,000 11:5
9 people would be enrolled across Texas." Do 11:5
10 you think that that was realistic, that you 11:5
11 could enroll 790,000 people in managed care 11:5
12 by fiscal year '97? 11:5
13 A. Not given the delay that happened as a result 11:5
14 of the legislative session. 11:5
15 Q. Meaning that because the legislature didn't 11:5
16 approve this by -- so that it could start in 11:5
17 January of '95, it wasn't possible to 11:5
18 complete that and within two years get 11:5
19 790,000 people? 11:5
20 A. Within those years we did not reach 790,000. 11:5
21 Q. Well, this is suggesting that within two 11:5
22 years from when you started, you would be 11:5
23 able to achieve enrollment of 790,000 11:5
24 people. 11:5
25 A. Uh-huh. 11:5

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1 Q. Okay. Do you know how much the enrollment is 11:5
2 as of today? 11:5
3 A. I don't have a specific number. Several 11:5
4 hundred thousand, but I don't know the exact 11:5
5 number. 11:5
6 Q. Less than half, probably, of that 790,000? 11:5
7 A. Yes, less than half of that. 11:5
8 Q. And what's the reason why it hasn't -- aside 11:5
9 from the legislature delaying going forward, 11:5
10 or approving the managed care, what's the 11:5
11 reason why it hasn't -- the state hasn't been 11:5
12 able to achieve the implementation at the 11:5
13 rate that this Option 1 seems to envision? 11:5
14 A. First of all, a four-month implementation 11:5
15 schedule proved to not be realistic. And in 11:5
16 conversations with Medicaid directors in 11:5
17 other parts of the country subsequent to 11:5
18 this, they advised a six-month minimum 11:5
19 implementation schedule, and that's proven to 11:5
20 be more true. 11:5
21 Secondly, we had a lawsuit which 11:5
22 slowed down implementation. Not only did the 11:5
23 legislature -- did the delay happen as a 11:5
24 result of the legislative session, but also 11:5
25 there was a lawsuit last summer which delayed 11:5

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1 implementation by at least a month, maybe two 11:5
2 months. 11:5
3 Q. What was the lawsuit? 11:5
4 A. Tarrant County Hospital District trying to 11:5
5 stop implementation of managed care. 11:5
6 Q. Why -- was there an injunction? 11:5
7 A. Yes. 11:5
8 Q. Okay. And that lasted for a month? 11:5
9 A. I don't recall how long it lasted. It ended 11:5
10 up pushing the project back a month. 11:5
11 Q. Any other reason? 11:5
12 A. Those are the reasons that I can think of. 11:5
13 MR. HAY: I'm finished with this 11:5
14 document. Do you want to break for lunch? 11:5
15 MR. HART: Yes. 11:5
16 THE VIDEOGRAPHER: Stand by. The 11:5
17 time is 11:59 a.m. We're going off the 11:5
18 record. 11:5
19 (LUNCH RECESS)
20 THE VIDEOGRAPHER: The time is 12:5
21 12:57 p.m. We're on the record. 12:5
22 **EXAMINATION**
23 BY MR. FENNELL:
24 Q. Ms. Friedholm, my name is Tom Fennell. I 12:5
25 think we've met before. 12:5

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1 A. Yes. 12:5
2 Q. I am representing R.J. Reynolds in this case 12:5
3 and I'm going to ask you a series of 12:5
4 questions. If you don't understand the 12:5
5 question, would you please indicate that to 12:5
6 me? 12:5
7 A. Yes. 12:5
8 Q. Otherwise it will be assumed that you 12:5
9 understood the question when you answered. 12:5
10 A. Yes. 12:5
11 Q. Okay. Ms. Friedholm, in the beginning of 12:5
12 this deposition on Monday, I think you 12:5
13 testified that you had prepared a list of 12:5
14 opinions along with your counsel to be used 12:5
15 in this case. Do you remember that 12:5
16 testimony? 12:5
17 A. Yes. 12:5
18 Q. I assume -- and that was completed and is 12:5
19 reflected, is it not, I believe, in Friedholm 12:5
20 Deposition Exhibit No. 4; is that correct? 12:5
21 A. 3. 12:5
22 Q. Number 3. And that's the list of opinions 12:5
23 you were referring to when you testified that 12:5
24 you had prepared in conjunction with your 12:5
25 counsel a list of opinions, correct? 12:5

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1 A. Yes. 12:5
2 Q. I assume, Ms. Friedholm, that you have 12:5
3 completed all of the work that you believed 12:5
4 was necessary to formulate those opinions; is 12:5
5 that correct?
6 A. Yes. 12:5
7 Q. Have you been asked to do any additional 12:5
8 work? 12:5
9 A. No. 12:5
10 Q. Do you feel like you have done all the work 12:5
11 that you need to do in connection with your 12:5
12 opinions in this case? 12:
13 A. Yes. 12:
14 Q. Since the deposition on Monday, have you met 12:
15 with counsel for the plaintiff? 12:5
16 A. No. Well, I mean, we met this morning and 12:5
17 we've met today, but no. 12:5
18 Q. Did you meet this morning in preparation for 12:5
19 the continuation of your deposition? 12:5
20 A. No. 12:5
21 Q. So you have not and did not discuss the 12:5
22 subject matter of your testimony on Monday 12:5
23 with counsel before beginning today; is that 12:5
24 correct?
25 A. No. Correct. 12:5

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1 Q. There was an exhibit that Mr. Hay showed you 12:5
2 which was the Title XIX expenditures. And, 12:5
3 Ms. Friedholm, for the record, that is part 12:5
4 of Friedholm Deposition Exhibit 2; is that 12:5
5 correct?
6 A. If you say so. 12:5
7 Q. Do you remember discussing Title IX 12:5
8 expenditure history list with Mr. Hay on 12:5
9 Monday? 12:5
10 A. Title XIX? 12:5
11 Q. Yes. 12:5
12 A. Yes. 12:5
13 Q. There was some questions asked by Mr. Hay 12:5
14 about certain of the categories of 12:5
15 expenditures listed in this exhibit. And 12:5
16 we're going to have to share, Ms. Friedholm. 12:5
17 If you recall, there was a category listed 12:5
18 called "Nonfed." 12:5
19 A. Yes. 12:5
20 Q. And I believe it was your testimony that that 12:5
21 represented dollars other than federal 12:5
22 dollars that were spent in the Medicaid 12:5
23 program. 12:5
24 A. Correct. 12:5
25 Q. My recollection was that you weren't certain 12:5

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1 what other nonfederal dollars were included 12:5
2 in that category; is that correct -- strike 12:5
3 that and let me ask it this way directly. 12:5
4 A. Okay. 12:5
5 Q. Can you tell us for the record what 12:5
6 percentage of the nonfederal dollars are 12:5
7 state-only dollars? 12:5
8 A. That would vary from year to year. 13:0
9 Q. Can you tell me just on average what 13:0
10 percentage of the nonfederal dollars would 13:0
11 represent State-only dollars? 13:0
12 A. Repeat the question. 13:0
13 Q. Can you just tell me on average or in a ball 13:0
14 park range what percent of the nonfederal 13:0
15 dollars represent state-only dollars? 13:0
16 A. No, I can't off the top of my head. 13:0
17 Q. Do you know in order of magnitude whether 13:0
18 we're talking about half or three-quarters of 13:0
19 the dollars or more of the dollars in the 13:0
20 category nonfederal represent state, as 13:0
21 opposed to other funding sources? 13:0
22 A. Without putting a specific percentage, the 13:0
23 majority of any nonstate nonfederal dollars 13:0
24 would be in the Disproportionate Share 13:0
25 Program, and beyond that it would be 13:0

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1 virtually all non -- I mean, all state funds 13:(
2 in the nonfederal line. I believe I said 13:(
3 that correctly. 13:(
4 Q. So when you say -- when you say virtually 13:(
5 all, you don't know whether that's 75 percent 13:(
6 or 80 percent or 90 percent on average? 13:(
7 A. I can't give you an average, but it is in 13:(
8 that range. 13:(
9 Q. If we look at this exhibit, this Title IX 13:(
10 expenditure history for a particular year, 13:(
11 let's take 1992, where it states that for 13:(
12 nonfederal under grant benefits there was 13:(
13 $1.6 billion, I believe if I'm reading that 13:(
14 correctly, roughly $1.6 billion dollars? 13:(
15 A. Uh-huh. 13:(
16 Q. Can you state for the record how many of 13:(
17 those dollars were state-only dollars? 13:(
18 A. No, I can't with any specificity. 13:(
19 Q. This exhibit would not tell you what the 13:(
20 actual state dollars were that were spent for 13:(
21 Medicaid; isn't that correct? 13:(
22 A. Not down to a specific dollar level, no. 13:(
23 Q. Does -- is there anything on this exhibit 13:(
24 which states what the actual monies were that 13:(
25 were spent for services, actual services as 13:(

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1 opposed to administrative fees or premiums or 13:
2 profits? 13:
3 A. The grant benefits column represents that 13:
4 amount. 13:
5 Q. Let me ask a couple of questions about that. 13:
6 When you say it represents that amount, does 13:
7 the grant benefits column represent payments 13:
8 of premiums to NHIC? 13:
9 A. It includes that. 13:
10 Q. So to the extent that there is profit in the 13:
11 premiums paid to NHIC, that's included in the 13:
12 grant benefits, correct? 13:
13 A. I'm not certain. 13:
14 Q. Is it your belief, sitting here today, that 13:
15 what is included in grant benefits is the 13:
16 premium amounts paid to NHIC? 13:
17 A. It is my belief today that these dollar 13:
18 amounts represent the amount of money the 13:
19 state spent, and I'm not certain as to 13:
20 whether it is an expenditure of total paid 13:
21 out or if it included it as a premium basis. 13:
22 I simply do not know. 13:
23 Q. Would you agree with me that when the state 13:
24 pays a premium to NHIC, that that includes 13:
25 not only the cost of providing some service, 13:

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1 but also some administrative costs for NHIC 13:(
2 and some profit to NHIC? 13:(
3 A. The -- there's two premiums. There's a 13:(
4 premium -- a benefit premium and an 13:(
5 administrative premium. 13:(
6 Q. Is the benefit premium also called a pure 13:(
7 premium? 13:
8 A. Yes. 13:
9 Q. Those two premiums both include a profit 13:
10 element, do they not? 13:
11 A. I'm not certain that I can use that 13:
12 terminology on the pure premium. 13:
13 Q. Does the pure premium include dollars other 13:
14 than dollars spent for cost of services, to 13:
15 your knowledge? 13:
16 A. I'm going to have to say I don't know how to 13:
17 answer that question. 13:
18 Q. Would it -- do you know the different ways in 13:
19 which NHIC profits from the Medicaid 13:
20 arrangement? 13:(
21 A. Well, I know some of them. I think I know 13:(
22 all of them, but I'm not sure. 13:
23 Q. Let's just kind of go through them. Why 13:
24 don't you list for me the different ways in 13:
25 which NHIC earns a profit from its 13:

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1 arrangement in connection with Medicaid with 13:(
2 the State of Texas? 13:(
3 A. Well, they have a potential for profit. 13:(
4 Q. We'll get to that in a minute, but I'm just 13:(
5 talking about the different ways in which 13:(
6 they can earn a profit. Let's talk about can 13:(
7 earn a profit. 13:(
8 A. On the administrative premium. 13:
9 Q. Okay. 13:
10 A. If they're able to reduce their costs of 13:
11 below the amounts that are agreed to. 13:
12 Q. Is that the second way or are you still 13:
13 talking about the -- 13:
14 A. No, that's the first one.
15 Q. -- administrative premium? 13:(
16 A. (Witness nods affirmatively.) 13:(
17 Q. Okay. So it's your understanding that the 13:(
18 administrative premium is the amount which 13:
19 NHIC will earn if it comes in below the 13:
20 negotiated premium with the state? 13:(
21 A. I don't understand what you're saying. Say 13:(
22 it again. 13:(
23 Q. Let's go back to just list -- let's list them 13:(
24 first, and then I'll come back to it. The 13:(
25 ways in which NHIC can earn a profit in terms 13:(

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1		of its arrangement with Texas, the first one	13:0
2		you mentioned is the administrative premium.	13:0
3		How else can NHIC earn a profit?	13:0
4	A.	On the pure premium to a certain amount where	13:0
5		they can benefit if we come in below the	13:0
6		estimated cost, but up to a certain amount.	13:0
7	Q.	That is, there's a cap on those profits?	13:0
8	A.	Right.	13:0
9	Q.	Okay. How else can NHIC earn a profit?	13:0
10	A.	Those are the two ways I know of.	13:0
11	Q.	Did until recently NHIC --	13:0
12	A.	Oh.	13:0
13	Q.	-- wasn't NHIC allowed to earn a profit on	13:0
14		the interest or investment --	13:0
15	A.	Yes.	
16	Q.	-- of the fund?	13:0
17	A.	Yes. I apologize. I forgot that.	13:0
18	Q.	And would you just tell the ladies and	13:0
19		gentlemen of the jury what this fund is that	13:0
20		we're talking about?	13:0
21	A.	It's a reserve fund and they are allowed to	13:0
22		invest those dollars in -- the state has	13:0
23		shared with it at various times different	13:0
24		percentages of -- different percentage	13:0
25		amounts of the interest gained on that	13:0

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1 account, based on investments of that money. 13:(
2 Q. In laymen's terms, the federal funds are 13:(
3 drawn down early, correct, or were drawn down 13:(
4 early? 13:(
5 A. Were, yes. 13:(
6 Q. And they were put into a fund and invested 13:(
7 until actually used to pay claims, correct? 13:(
8 A. Correct. 13:(
9 Q. And it was the investment earnings during 13:(
10 that period of time before they were actually 13:(
11 used that were split between the state and 13:(
12 NHIC, correct? 13:(
13 A. Yes. 13:(
14 Q. Now, that was done up until what year? 13:(
15 A. 1994, I believe. 13:(
16 Q. Okay. And it was done in every year in which 13:(
17 this agreement was in effect with NHIC up to 13:(
18 1994; is that correct? 13:(
19 A. It's my understanding, yes. 13:(
20 Q. Okay. Was there ever, by the way, an 13:(
21 accounting done by the state as to what the 13:(
22 profit was that was made by NHIC in terms of 13:(
23 its collection of these investments off this 13:(
24 fund? 13:(
25 A. The state monitored that. I don't know that 13:(

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1 there was a -- to answer your question 13:(
2 specifically, I'm not aware of a single 13:(
3 report. 13:(
4 Q. Well, did you ever see a report, whether 13:(
5 single or in combination with other matters, 13:(
6 that set out here is what NHIC is making from 13:(
7 the investments on this money? 13:
8 A. Well, I would -- I saw reports that showed 13:
9 what the state yielded and we knew what our 13:
10 percentage was. 13:
11 Q. Okay. And those reports -- you saw those 13:
12 reports; is that correct? 13:
13 A. I believe so. 13:
14 Q. And was that part of your job when you were 13:
15 Medicaid director, was to see those reports? 13:
16 A. Not on a regular basis. 13:
17 Q. Okay. In order of magnitude, 13:
18 Ms. Friedholm -- I understand you may not 13:
19 know the precise dollars -- but in order of 13:
20 magnitude, can you state on a yearly basis 13:
21 the amount of money that NHIC was making on 13:
22 these investments on this fund during the 13:
23 existence of this arrangement? 13:
24 A. No, I cannot. 13:
25 Q. Do you know whether it was in the tens of 13:

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1 millions of dollars? 13:(
2 A. No, I do not. 13:(
3 Q. What about -- those are three ways in 13:(
4 which -- and we have talked about one -- 13:(
5 three ways in which NHIC could profit from 13:
6 this arrangement. Was there a fourth way in 13:
7 the sense that the money was taken out of 13:
8 this fund, I understand, and paid to NHIC who 13:
9 would then in turn pay claims to providers, 13:
10 correct? 13:
11 A. Uh-huh. Yes. 13:
12 Q. Could they earn money on the float, that is, 13:
13 on the time period between payment to them 13:
14 and payment to a provider, if you know? 13:
15 A. I'm not recalling. 13:
16 Q. Okay. Was there ever an evaluation done by 13:
17 the state of what the total profit was being 13:
18 made by NHIC from all of these various 13:
19 sources in any particular year that you're 13:
20 aware of? 13:
21 A. I'm not remembering any, no. 13:
22 Q. Did you ever see a report that looked back at 13:
23 NHIC's profits that said, you know, here's 13:
24 what NHIC has been making every year, you 13:
25 know, X million dollars or X tens of millions 13:

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1 of dollars on this arrangement? Did you ever 13:1
2 see a report like that? 13:1
3 A. Not that I recall. 13:1
4 Q. Did you ever ask that a report like that be 13:1
5 done to determine the profitability of this 13:1
6 arrangement to NHIC? 13:1
7 A. We discussed -- in the process of this Lewin 13:1
8 report, we had discussions with the state 13:1
9 staff who oversaw the contract about those 13:1
10 ranges of dollars, but I don't recall ever 13:1
11 seeing anything specifically in writing. 13:1
12 Q. When you say discussions with the state 13:1
13 staff, was a request made by you or those 13:1
14 people reporting to you to have the state 13:1
15 staff do an evaluation of NHIC's profit? 13:1
16 A. Not that I recall in a formal sense. 13:1
17 Q. Do you know whether that state staff or 13:1
18 anyone reporting to you did that kind of an 13:1
19 evaluation in connection with the Lewin 13:1
20 report? 13:1
21 A. I don't remember any more. 13:1
22 Q. Do you know whether there was any report done 13:1
23 prior to the Lewin report, that is, any 13:1
24 evaluation of NHIC's profits under the 13:1
25 arrangement with Texas -- the State of Texas? 13:1

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1 A. Not that I'm aware of. 13:1
2 Q. Do I understand -- I think you testified that 13:1
3 I believe it was set out in these documents 13:1
4 that in terms of the pure premium, that is, 13:1
5 the potential for NHIC to make a profit if it 13:1
6 came in below the estimated costs, that it 13:1
7 made the maximum, that is, the capped profit 13:1
8 in every year; isn't that correct? 13:1
9 A. That's what Mr. Hay has represented. I don't 13:1
10 have any independent way to -- 13:1
11 Q. You don't have any basis -- do you have any 13:1
12 reason to doubt that? 13:1
13 A. I don't. 13:1
14 Q. In fact, if I'm not mistaken, Ms. Friedholm, 13:1
15 you have in the past been critical, have you 13:1
16 not, of the NHIC arrangement? 13:1
17 A. Well, I have -- I was concerned about it, 13:1
18 which led to the reviews that we did with 13:1
19 Lewin. 13:1
20 Q. All right. Concerned because it was your 13:1
21 view that it was excessively profitable to 13:1
22 NHIC and disadvantageous to the state, 13:1
23 correct? 13:1
24 A. I was -- I -- my main concern was that the 13:1
25 state might be spending too much money 13:1

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1 because patients were not able to use the 13:1
2 services that the system was paying premiums 13:1
3 on. 13:1
4 Q. And -- 13:1
5 A. And that was -- and which could lead to 13:1
6 being -- spending more money than we should. 13:1
7 Q. And I understand that was your main concern. 13:1
8 I think you testified to that before, but a 13:1
9 concern of yours expressed, was it not, was 13:1
10 that the NHIC arrangement was too profitable 13:1
11 for NHIC and disadvantageous to the state? 13:1
12 A. I was concerned about it, yes. 13:1
13 Q. Did anyone prior -- anyone that you -- let me 13:1
14 strike that. 13:1
15 Ms. Friedholm, you, I think, began 13:1
16 as Medicaid director in January of '93. 13:1
17 A. Yes. 13:1
18 Q. And served in that capacity for almost four 13:1
19 years, correct? 13:1
20 A. Actually three. 13:1
21 Q. To November '96? 13:1
22 A. '95. 13:1
23 Q. Oh, November '95. Okay. And prior to that, 13:1
24 you were the special assistant to Lieutenant 13:1
25 Governor Bullock? 13:1

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1 A. Yes. 13:1
2 Q. And that began 1990? 13:1
3 A. Yes. 13:1
4 Q. And you worked at health and human services 13:1
5 coordinating council from '88 to '90, 13:1
6 correct? 13:1
7 A. No. 13:1
8 Q. No? Okay. Where did you work -- when did 13:1
9 you work with the HHS coordinating council? 13:1
10 A. 1986. 13:1
11 Q. In the course of performing your job in those 13:1
12 various capacities, did you go back to 13:1
13 evaluate what had been done by the state in 13:1
14 connection with its Medicaid program? Did 13:1
15 you go back to learn the history of the 13:1
16 program, what changes had been made in the 13:1
17 program, what evaluations had been done of 13:1
18 the program? 13:1
19 A. Well, yes, I did do that during those periods 13:1
20 of time. 13:1
21 Q. And in doing that, did you ever see that 13:1
22 prior to the Lewin report that there was any 13:1
23 evaluation by the State of Texas of the 13:1
24 propriety or profitability of NHIC or the 13:1
25 disadvantage of that arrangement to NH -- to 13:1

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1 the State of Texas? 13:1
2 A. No, and I would not have expected to. 13:1
3 Q. Why would you have not expected it? 13:1
4 A. It just wasn't a major area that I worked on 13:1
5 during those periods of time that you 13:1
6 mentioned. 13:1
7 Q. And sitting here today, you're not aware of 13:1
8 any such report? 13:1
9 A. I don't -- I'm not aware, no. 13:1
10 Q. In terms of the pure premium, you said there 13:1
11 was a cap on the profitability of NHIC under 13:1
12 that particular premium, correct? 13:1
13 A. I believe so. 13:1
14 Q. And that is to say that if the experience in 13:1
15 a particular year was less than the costs, 13:1
16 considerably less than the costs, NHIC could 13:1
17 earn a profit, but only up to a certain point 13:1
18 and then it would just stop, correct? 13:1
19 A. I believe so, yes. 13:1
20 Q. And, in fact, the costs have actually been 13:1
21 significantly lower than the forecast than 13:1
22 even the place where it's capped under this 13:1
23 arrangement with NHIC; isn't that correct? 13:1
24 A. In some years. I'm not sure that that's true 13:1
25 in all years. 13:1

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1 Q. Have you ever examined that to see whether or 13:1
2 not costs have actually been even lower than 13:1
3 the capped amount? 13:1
4 A. We discussed that with staff when we were 13:1
5 working on the Lewin -- putting together the 13:1
6 Lewin study. 13:1
7 Q. So there was some -- 13:1
8 A. I don't know that I've seen anything in 13:1
9 writing about it, but it was discussed. 13:1
10 Q. And did the discussion indicate that, in 13:1
11 fact, the experience was coming in so far 13:1
12 below cost that you were capping in every 13:1
13 year; in fact, there was a margin there that 13:1
14 hadn't even been used up? 13:1
15 A. I don't -- I don't remember that anymore. 13:1
16 Q. Okay. You don't know one way or the other; 13:1
17 is that correct?
18 A. I can't recall anymore. 13:1
19 Q. You mentioned that there's an incentive in 13:1
20 this contract for NHIC to be paying its 13:1
21 claims properly; that is, not to pay 13:1
22 undeserving claims because it wants to 13:1
23 maximize its profit, correct? 13:1
24 A. Yes. 13:1
25 Q. Would you agree with me that if in every year 13:1

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1 the amount by which the experience is below 13:1
2 cost greatly exceeds the cap, that NHIC loses 13:1
3 that incentive? 13:1
4 A. Not necessarily, but it lessens the 13:1
5 incentive. 13:1
6 Q. Okay. I mean, if NHIC knows that every year 13:1
7 that its experience is going to be so far 13:1
8 below cost it's going to cap out no matter 13:1
9 what it does, it doesn't have an interest 13:1
10 anymore in being all that rigorous in its 13:1
11 claims payment, agreed? 13:1
12 A. Yeah, in theory. 13:1
13 Q. And you just don't know what the history has 13:1
14 been in terms of how far below the cap actual 13:1
15 experience has been relative to cost? 13:1
16 A. No. 13:1
17 Q. Is that correct? 13:1
18 A. Correct. 13:1
19 Q. Now, you, I think, characterized -- and I 13:1
20 don't want to put words in your mouth. If 13:1
21 I'm wrong on this, Ms. Friedholm, tell me. 13:1
22 But I thought you had said that you had made 13:1
23 an effort when you were Medicaid director to 13:1
24 strike a better deal with NHIC, and indeed 13:1
25 did that, in your view, starting in 1994, 13:1

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1 correct? 13:1
2 A. Yes. 13:1
3 Q. Do you know whether anyone else prior to 13:1
4 your -- your term as Medicaid director ever 13:1
5 did what you did, and that is go back to NHIC 13:1
6 to get this kind of better deal that you got 13:1
7 in 1994? 13:1
8 A. I don't have any way to know that. 13:1
9 Q. Are you aware of anybody ever having done 13:1
10 that, other than you? 13:1
11 A. No. 13:1
12 Q. On the administrative premium, you said there 13:
13 was a profit earned on the administrative 13:
14 premium? 13:
15 A. Well, if their costs come in below the 13:
16 negotiated rate that we have with them, I 13:
17 presume that's profit. 13:
18 Q. So your understanding that this capped 13:
19 profit, if their experience is below 13:
20 estimated costs, is the factor that supplies 13:
21 the profit element of both the administrative 13:
22 premium and the pure premium; is that 13:
23 correct?
24 A. I believe so, yes. 13:
25 Q. Okay. So in your understanding of it, there 13:

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1 is not a fixed profit element to the 13:2
2 administrative premium; is that correct? 13:2
3 A. I'm not sure. 13:2
4 Q. Okay. Did you ever analyze that or have 13:2
5 someone do that? 13:2
6 A. The answer is yes, it was done for 1994, but 13:2
7 I don't recall the specifics of it anymore. 13:2
8 Q. Sounds like there was a fair amount of 13:2
9 analysis of this NHIC contract in the '94 13:2
10 time period about the time of the Lewin 13:2
11 report, correct? 13:2
12 A. Lewin was in '91. There was a decision made 13:2
13 to extend the contract for two years, and in 13:2
14 1994 we had to decide whether to extend or to 13:2
15 bid it out. So there was a second round of 13:2
16 analysis and work around the contract. 13:2
17 Q. Now, we digressed a bit, Ms. Friedholm, from 13:2
18 this exhibit, and I want to go back to it. 13:2
19 That is, the portion of Exhibit 2 which is 13:2
20 captioned "Title XIX Expenditure History 13:2
21 List." And look at the "Grant Benefits" 13:2
22 column again. And let me ask as to that 13:2
23 column entitled "Grant Benefits" whether that 13:2
24 would include profits to providers and 13:2
25 administrative costs of providers in addition 13:2

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1 to the cost of the actual health care 13:2
2 services, if you know. 13:2
3 A. Profits to providers? Yes. Administrative 13:2
4 costs to providers, yes again. There's no 13:2
5 separate reimbursement to them. 13:2
6 Q. Is there any way -- is there any way, 13:2
7 Ms. Friedholm, from this exhibit to determine 13:2
8 the actual costs of health care services that 13:2
9 are being provided to Medicaid recipients in 13:2
10 any given year? 13:2
11 A. Well, these are the costs to the program of 13:2
12 those services. 13:2
13 Q. Which includes administrative costs to NHIC 13:2
14 and profits to NHIC and administrative costs 13:2
15 to providers and profits to providers, 13:2
16 correct? 13:2
17 A. I don't know about the NHIC-related part, as 13:2
18 I had testified earlier. I don't know about 13:2
19 the administrative -- whether that was 13:2
20 included under administration or not. And on 13:2
21 providers, yes, it does include those two 13:2
22 things because those are built into the 13:2
23 payments that we make them. 13:2
24 Q. Is there any effort to separate out health 13:2
25 care services from other kinds of services 13:2

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1 provided under the Medicaid program such as 13:2
2 transportation costs or living costs, that 13:2
3 sort of thing? 13:2
4 A. Living costs? 13:2
5 Q. I mean, like daily living -- I assume this 13:2
6 includes nursing homes; is that correct? 13:2
7 A. Yes. 13:2
8 Q. And then what I'm asking is whether there was 13:2
9 ever a separate tally of health care costs as 13:2
10 separate from other kinds of expenditures by 13:2
11 the Medicaid program. 13:2
12 A. Transportation is a separate -- not on this 13:2
13 document, no. But transportation is a 13:2
14 separate line item in the Medicaid program. 13:2
15 Q. Right. 13:2
16 A. And the cost of nursing home care include 13:2
17 that whole range of services that are 13:2
18 eligible services that are required by people 13:2
19 because of their need. 13:2
20 Q. Okay. 13:2
21 A. So those are all in -- in the totals. 13:2
22 Q. Let me come back to that. On the 13:2
23 administrative cost, which is this 13:2
24 administration category, Ms. Friedholm, I 13:2
25 think your testimony before was that you were 13:2

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1 not sure if that administrative cost item or 13:2
2 column represents just the state's 13:2
3 administrative costs or whether it also 13:2
4 includes all of the NHIC costs, and that was 13:2
5 on Monday. Have you done anything between 13:2
6 Monday and today to find out whether it does 13:2
7 or does not include NHIC administrative 13:2
8 costs? 13:2
9 A. No. 13:2
10 Q. In your testimony, you had testified that 13:2
11 there was -- in the Texas program its 13:2
12 administrative costs were three to four 13:2
13 percent of total expenditures. Do you 13:2
14 remember that? 13:2
15 A. Yes. 13:2
16 Q. I assume you don't know, sitting here today, 13:2
17 whether that testimony, the three to four 13:2
18 percent, includes the NHIC costs -- 13:2
19 administrative costs or not; is that correct? 13:2
20 A. Correct. That's the same as Monday. 13:2
21 Q. Right. Okay. And you haven't done anything 13:2
22 yet -- you haven't -- between Monday and 13:2
23 today you didn't check to determine whether 13:2
24 or not that three to four percent includes 13:2
25 NHIC administrative costs? Correct? 13:2

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1 A. Correct. 13:2
2 Q. Your testimony on Monday was that there had 13:2
3 been -- in a comparison of Texas to other 13:2
4 states in terms of administrative costs per 13:2
5 recipient, you thought Texas did very well. 13:2
6 Do you recall that testimony? 13:2
7 A. Yes. 13:2
8 Q. That's based on the three to four percent 13:2
9 number that you're using for the 13:2
10 administrative costs -- 13:2
11 A. Yes. 13:2
12 Q. -- of the Texas Medicaid program. 13:2
13 A. Yes. 13:2
14 Q. Would you agree that if it does not include 13:2
15 the NHIC administrative costs, that that may 13:2
16 not be a fair comparison to other states who 13:2
17 administer their own program or include the 13:2
18 fees of a -- of an administrator in their 13:2
19 expenditures? 13:2
20 A. Yes. 13:2
21 Q. You need to compare apples to apples? 13:2
22 A. Absolutely. 13:2
23 Q. And you don't know, sitting here today, 13:2
24 whether that comparison that you were 13:2
25 referring to is ~~an~~ apples-to-apples 13:2

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1 comparison, correct? 13:2
2 A. I can't specific -- I can't be certain about 13:2
3 it, no. 13:2
4 Q. So you don't know whether Texas looks good or 13:2
5 looks bad compared to other states if you 13:2
6 look at all administrative costs, correct? 13:2
7 A. Correct. 13:2
8 Q. Okay. Ms. Friedholm, I think you testified 13:2
9 that you were a lobbyist for the Children's 13:2
10 Hospital Association. 13:2
11 A. I was an advisor to the Children's Hospital 13:2
12 Association.
13 Q. And helped promote legislation and, I missed 13:2
14 the name of it, but it was like Texas Healthy 13:2
15 Kids? 13:2
16 A. Right. 13:2
17 Q. Is that the name of the legislation? 13:2
18 A. I've worked with that group on that 13:2
19 initiative. 13:2
20 Q. When was that adopted? 13:2
21 A. This year. 13:2
22 Q. And was its purpose in part to increase 13:2
23 access to preventive care and to increase 13:2
24 early intervention? 13:2
25 A. It was to encourage the development of health 13:2

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1 care products by the private sector that 13:2
2 individual families can afford or small 13:2
3 businesses can afford to purchase with an 13:2
4 idea that that would include preventive 13:2
5 services for those uninsured children. 13:2
6 Q. So at bottom, was the notion that if we can 13:2
7 get more and better care to children early, 13:2
8 we can have a healthier population and in the 13:2
9 long run save costs as well? 13:2
10 A. Yes. 13:2
11 Q. And I take it -- strike that. 13:2
12 Was it your concern that there was 13:2
13 not enough of these kinds of programs being 13:2
14 offered in the past, that is, there was a 13:2
15 deficiency in the care being provided to 13:2
16 children in Texas? 13:2
17 A. There is a deficiency in the availability of 13:2
18 affordable health insurance for working 13:2
19 families in Texas. 13:2
20 Q. And it wasn't being picked up by Medicaid? 13:2
21 A. No. These are for people who cannot qualify 13:2
22 for Medicaid -- 13:2
23 Q. You're talking about the --
24 A. -- children who do not qualify for Medicaid. 13:2
25 Q. You're talking about the uninsured children 13:2

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1 in Texas? 13:2
2 A. Yes. 13:2
3 Q. By the way, when we refer to uninsured, we 13:2
4 mean not having private insurance or Medicaid 13:2
5 insurance? 13:2
6 A. Correct. No -- no source of third-party 13:2
7 payment. 13:2
8 Q. Okay. I mean, when we -- when the state 13:2
9 uses -- I see in a lot of the documents 13:2
10 calculations -- in fact, you used in "Texas 13:2
11 Medicaid in Perspective" this term 13:2
12 "uninsured," and I wasn't sure whether you 13:2
13 were including Medicaid as an insurance 13:2
14 program. 13:2
15 A. Yes, we included it as an insurance program. 13:2
16 Q. Okay. And that's what it is essentially is a 13:2
17 state insurance program, correct? 13:2
18 A. Yes. 13:2
19 Q. And you -- and indeed, not only does the 13:2
20 Texas Medicaid program operate as an insurer, 13:2
21 but it pays a premium to another insurer in a 13:2
22 sense. It pays a premium to NHIC, correct, 13:2
23 in the past -- let me strike that and start 13:2
24 over. 13:2
25 A. Thank you. 13:2

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1 Q. Okay. Texas Medicaid program operates as an 13:3
2 insurance to Texas citizens, low-income 13:3
3 citizens if they meet certain 13:3
4 classifications? 13:3
5 A. It serves as a payer, yes. 13:3
6 Q. And in the past, what Texas Medicaid has done 13:3
7 until the implementation of managed care is 13:3
8 to pay a premium to NHIC, correct? 13:3
9 A. When it had its contract with NHIC, yes. 13:3
10 Q. And NHIC is an insurance company, isn't it? 13:3
11 A. Yes. 13:3
12 Q. I mean, it's National Heritage Insurance 13:3
13 Company. 13:3
14 A. Correct. 13:3
15 Q. So Texas operating as an insurer is paying an 13:3
16 insurance company, NHIC, who then pays 13:3
17 recipients, Medicaid recipients, correct? 13:3
18 A. No. 13:3
19 Q. I'm sorry. Then pays providers, correct? 13:3
20 A. Yes. 13:3
21 Q. Okay. So in essence, you've got two layers 13:3
22 of insurance. You've got the state who is 13:3
23 providing -- operating as an insurer paying 13:3
24 an insurance company who then pays claims, 13:3
25 correct? 13:3

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1 A. The state operates as a payer, but must 13:3
2 provide whatever dollars are necessary to 13:3
3 cover the costs of those individuals who are 13:3
4 qualified. 13:3
5 Q. Well, let me ask it this way: I think maybe 13:3
6 we're on different tracks. When the state 13:3
7 pays a premium to NHIC, it is not making a 13:3
8 payment directly to a provider for a health 13:3
9 care claim. 13:3
10 A. Correct. 13:3
11 Q. It is paying money in the form of a 13:3
12 negotiated premium to an insurance company, 13:3
13 correct? 13:3
14 A. Yes. 13:3
15 Q. Who then pays some claims as they come in, 13:3
16 correct? 13:3
17 A. Yes. 13:3
18 Q. And the claims may or may not amount to the 13:3
19 total negotiated premium, correct? 13:3
20 A. Correct. 13:3
21 Q. I mean, that's the whole basis for the 13:3
22 potential profitability of NHIC. 13:3
23 A. Right. 13:3
24 Q. So when we make a payment, that is, when the 13:3
25 State of Texas makes a payment to NHIC, it is 13:3

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1 making a payment that is not identical to or 13:3
2 the equivalent of the health care payments 13:3
3 being incurred by Medicaid recipients, 13:3
4 correct? 13:3
5 A. Not identical to. 13:3
6 Q. Something above that? 13:3
7 A. Depends. 13:3
8 Q. Well, it's paying certainly premiums to NHIC, 13:3
9 correct? 13:3
10 A. Yes. 13:3
11 Q. And in those premiums are at least 13:3
12 administrative costs and profits to NHIC, 13:3
13 potentially, correct? 13:3
14 A. Yes. 13:3
15 Q. Okay. So it's not paying just the claim 13:3
16 amount to NHIC. It's paying something above 13:3
17 and beyond the claim amount to NHIC. 13:3
18 A. I see what you're saying. Yes. 13:3
19 Q. So there's not a -- my point, 13:3
20 Ms. Friedholm -- it's a long way to make 13:3
21 it -- is there's not a one-to-one 13:3
22 correspondence between the payment Texas 13:3
23 makes to NHIC and the actual claims that NHIC 13:3
24 gets from recipients or providers for 13:3
25 recipient services, correct? 13:3

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1 A. Correct. 13:3
2 Q. Okay. We got off on a side track. You -- 13:3
3 you were talking about the Children's 13:3
4 Hospital Association and your work and the 13:3
5 notion that there was an effort to provide 13:3
6 health care products to children in Texas who 13:3
7 were uninsured. 13:3
8 A. Yes. To make those available to them. 13:
9 Q. And the underlying purpose of doing that was 13:
10 to increase the availability of preventive 13:
11 care and early intervention, correct, among 13:
12 other things? 13:
13 A. Among other things, yes. 13:
14 Q. And the view was that we would have healthier 13:
15 people who would get less sick if they had 13:
16 preventive care and early intervention care, 13:
17 correct? 13:
18 A. Yes. 13:
19 Q. You also worked -- and I may pronounce this 13:
20 wrong -- for the Benedictine Resource Center? 13:
21 A. Yes. 13:
22 Q. Can you tell me what that is? 13:
23 A. It was a small 501(c)3 research policy office 13:
24 which concerned itself with the situation of 13:
25 low-income people in Texas. 13:

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1 Q. And you served, I think, on a committee which 13:3
2 was called the Maternal and Child Health Care 13:3
3 Advisory Committee? 13:3
4 A. Yes. 13:3
5 Q. And that was in the time period of what, 1988 13:3
6 to 1990? 13:3
7 A. Approximately. I don't remember the exact 13:
8 dates. 13:
9 Q. And is it -- correct me if I'm wrong. It's 13:
10 my understanding that basically your work in 13:
11 this committee was to be an advocate for more 13:
12 and better preventive and prenatal care. 13:
13 A. Yes. 13:
14 Q. Okay. In fact, there was a document I think 13:
15 you authored or coauthored which was called 13:
16 "Women and Children First"? 13:
17 A. Yes. 13:
18 Q. Okay. Ms. Friedholm, this is a long way to 13:
19 ask this question, I know, but you're a 13:
20 strong advocate of preventive care, are you 13:
21 not? 13:
22 A. Yes. 13:
23 Q. And it is your view that preventive care and 13:
24 early intervention care can make not only for 13:
25 healthier people, but lower costs in the long 13:

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1 run, correct? 13:3
2 A. Yes. 13:3
3 Q. And indeed in the Medicaid population I 13:3
4 believe you testified in response to Mr. Hay
5 that because you can keep people out of 13:3
6 higher cost alternatives like emergency 13:3
7 rooms, it both has a short-term cost benefit 13:3
8 and a long-term cost benefit, correct? 13:3
9 A. It can, yes. 13:3
10 Q. Short-term in the sense that it keeps people 13:3
11 from using emergency rooms and other higher 13:3
12 cost alternatives, correct? 13:3
13 A. What does? What's your -- what's your 13:3
14 subject?
15 Q. That is, preventive care. 13:3
16 A. Preventive care? 13:3
17 Q. And early intervention care can prevent the 13:3
18 use of higher cost alternatives like 13:3
19 emergency rooms and therefore save in the 13:3
20 short run costs of the Medicaid program, 13:3
21 correct? 13:3
22 A. Yes, that's correct. 13:3
23 Q. And in the long term it can make for 13:3
24 healthier people and therefore save Medicaid 13:3
25 money in the long-term as well, correct? 13:3

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1 A. Yes. 13:3
2 Q. And you have favored, have you not, in your 13:3
3 tenure as Medicaid director and otherwise an 13:3
4 expansion of eligibility, Medicaid 13:3
5 eligibility in order to do, among other 13:3
6 things, improve access to preventive and 13:3
7 early intervention care, correct? 13:3
8 A. Yes. I've advocated all kinds of expansions 13:3
9 to get people access to health care, not just 13:3
10 Medicaid. 13:3
11 Q. And because it makes people healthier and it 13:3
12 can save costs in the long run and short run, 13:3
13 correct? 13:3
14 A. Yes, and for the benefit of individuals. 13:3
15 Q. Yes. I said health -- and healthier people, 13:3
16 too, which is a very good goal, correct? 13:3
17 A. Yes. 13:3
18 Q. And you have favored not only increasing 13:3
19 eligibility, but increasing expenditures to 13:3
20 those who are already eligible for Medicaid 13:3
21 in the area of preventive and early 13:3
22 intervention care, correct? 13:3
23 A. Yes, I believe so. 13:3
24 Q. Well, and it doesn't just go for the 13:3
25 traditional Medicaid groups. I believe your 13:3

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1 testimony was in the nursing home area, for 13:3
2 example, that you had favored a proposal to 13:3
3 change reimbursement methodology to encourage 13:3
4 nursing homes to provide more health care 13:3
5 services so that there is more health care 13:3
6 provided by nursing homes, as opposed to just 13:3
7 daily living kinds of services provided, 13:3
8 correct? 13:3
9 A. Not exactly. The proposal would have 13:3
10 rewarded those nursing homes that spent 13:3
11 adequately on staffing and on food, for 13:3
12 example, were the two examples I generally 13:3
13 use, for individuals to receive higher 13:3
14 quality care than they in some cases get now 13:3
15 in the Medi -- in the nursing home system 13:3
16 that's reimbursed on a flat rate. 13:3
17 Q. Were you seeking to provide or have nursing 13:3
18 homes provide more or better quality health 13:3
19 care, or just better daily living services? 13:3
20 A. Overall actually both. 13:3
21 Q. Both? 13:3
22 A. Yes. 13:3
23 Q. Is it your view that there was some 13:3
24 inadequacies on the part of nursing homes in 13:3
25 providing health care, that is, that they 13:3

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1 were diverting too many dollars into profits 13:3
2 or administrative fees or daily living, as 13:3
3 opposed to providing true health care? 13:3
4 A. I would say the concern was that in all areas 13:3
5 of care for patients that they are under a 13:4
6 flat rate system, it is a -- an easier 13:4
7 situation for nursing homes to divert dollars 13:4
8 away from direct patient care, which I say 13:4
9 includes all aspects of that care -- 13:4
10 Q. So --
11 A. -- medical and daily living and -- 13:4
12 Q. Was it your observation --
13 A. -- answering buzzers when somebody buzzes. 13:4
14 Q. Was it your observation that nursing homes 13:4
15 were, in fact, diverting monies away from 13:4
16 care for patients and using it instead for 13:4
17 administrative costs or profits? 13:4
18 A. There has been that long-standing concern, 13:4
19 and our concern was we didn't -- we didn't 13:4
20 think enough incentive was being placed on 13:4
21 the direct patient care part of the 13:4
22 reimbursement methodology. 13:4
23 Q. When you say not enough incentive on it, you 13:4
24 mean not enough dollars paid to nursing homes 13:4
25 were being used for that purpose, correct? 13:4

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1 A. That was our concern. 13:4
2 Q. And so not enough dollars were being paid -- 13:4
3 were being used by nursing homes for health 13:4
4 care for the patients, as opposed to for 13:4
5 profits or administrative costs or other 13:4
6 kinds of services, correct? 13:4
7 A. In some instances I think that's true. I 13:4
8 can't say absolutely across the board. There 13:4
9 was wide vary -- variation. 13:4
10 Q. But overall that was a problem, wasn't it? 13:4
11 A. It was a general problem to the whole system, 13:4
12 and I believed could be corrected by changing 13:4
13 the methodology of how we paid nursing homes. 13:4
14 Q. In fact, there has been some analysis of the 13:4
15 profitability of nursing homes in the State 13:4
16 of Texas, has there not? 13:4
17 A. Yes, I believe so. 13:4
18 Q. And rates of return in nursing homes are on 13:4
19 the order of 30 percent or more, correct? 13:4
20 A. I don't know the number. 13:4
21 Q. Do you know what on average the rate of 13:4
22 return has been for nursing homes in the 13:4
23 State of Texas? 13:4
24 A. I don't know the number. 13:4
25 Q. For any year? 13:4

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1 A. I don't know the number. 13:4
2 Q. Okay. When you were Medicaid director, did 13:4
3 you ask that that be investigated? 13:4
4 A. We looked at a variety of issues around 13:4
5 nursing home payments, again with the idea of 13:4
6 trying to move to this different system. 13:4
7 Q. Did you -- 13:4
8 A. And that may have been one of the things. I 13:4
9 don't remember anymore a specific request. 13:4
10 Q. Sitting here today, do you recall ever having 13:4
11 seen an analysis of the profitability of 13:4
12 nursing homes? 13:4
13 A. Well, what I remember seeing here today were 13:4
14 long debates with the industry about what 13:4
15 constituted profit. So we must have had some 13:4
16 numbers that we were using as profit and they 13:4
17 argued with us about what was profit and what 13:4
18 was not. But I don't remember anymore the 13:4
19 actual figures. 13:4
20 Q. Okay. Do you recall that there was -- if you 13:4
21 don't recall the actual figures -- a concern 13:4
22 by the state, by you and others, about the 13:4
23 fact that the profits were excessive for 13:4
24 nursing homes? 13:4
25 A. For some nursing homes. 13:4

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1 Q. Well, what about on average for nursing homes 13:4
2 in the State of Texas? 13:4
3 A. I don't know about an average. The industry 13:4
4 is very diversified in the way they care for 13:4
5 and spend money on patients, that there was a 13:4
6 concern that there was some nursing home 13:4
7 chains that did not offer a high standard of 13:4
8 quality of care and yet at the same time 13:4
9 seemed to be doing fine financially. 13:4
10 Q. And by fine financially, you mean excessive 13:4
11 profits? 13:4
12 A. Making -- making profits at a time that the 13:4
13 quality of care seemed to be sacrificed. I 13:4
14 don't know what excessive is, but as long as 13:4
15 the quality of care was not good -- 13:4
16 Q. Would you agree that 30 percent rates of 13:4
17 return would be excessive profits? 13:4
18 A. I would have to look at that in conjunction 13:4
19 with quality, but, yes, generally I would. 13:4
20 Q. We got diverted again, Ms. Friedholm. So let 13:4
21 me go back. We were talking about the fact 13:4
22 that you have been an advocate to expand 13:4
23 Medicaid eligibility and to expand 13:4
24 expenditures for existing -- existing 13:4
25 Medicaid eligibles in order to improve access 13:4

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1 to preventive and early care. Do you 13:4
2 remember that when we were talking about 13:4
3 that? I'm just trying to get us back to 13:4
4 where we were. 13:4
5 A. I'm -- yes. 13:4
6 Q. I'm not going to ask those questions over 13:4
7 again. Do you remember that discussion just 13:4
8 a few minutes ago? 13:4
9 A. Yes. 13:4
10 Q. Okay. And my question to you is this: Would 13:4
11 you agree with me that low expenditures per 13:4
12 Medicaid recipient is not necessarily good 13:4
13 either for the recipients or for the State of 13:4
14 Texas?
15 A. I would have to say that depends. 13:4
16 Q. Would you agree that low expenditures per 13:4
17 recipient in the State of Texas is 13:4
18 inconsistent with your view, previously 13:4
19 espoused view that expenditures for Medicaid 13:4
20 recipients ought to be expanded and that 13:4
21 eligibility ought to be expanded? 13:4
22 A. Not necessarily. 13:4
23 Q. Is it your view that low expenditures per 13:4
24 Medicaid recipient is good? 13:4
25 A. Not necessarily. 13:4

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1 Q. I understand not necessarily, but let's take 13:4
2 the situation in Texas. 13:4
3 A. Okay. 13:4
4 Q. We may be talking -- we may be on a 13:4
5 theoretical level. Let's bring it down to 13:4
6 the State of Texas. 13:4
7 A. Okay. 13:4
8 Q. According to "Texas Medicaid in Perspective," 13:4
9 Texas has one of the highest uninsured 13:4
10 populations in the country. 13:4
11 A. Yes. 13:4
12 Q. The highest, according -- 13:4
13 A. Any given moment, we're one or two, depending 13:4
14 on whose survey it is, but, yes. 13:4
15 Q. Is that good? 13:4
16 A. I don't believe so. 13:4
17 Q. And in terms of Medicaid dollars spent per 13:4
18 recipient, we are one of lowest states in the 13:4
19 union, correct? 13:4
20 A. Yes. 13:4
21 Q. Is it your view that that's good? 13:4
22 A. Not necessarily, but it doesn't have anything 13:4
23 to do with our rate of uninsurance. You 13:4
24 asked those two things together and I don't 13:4
25 tie those two things together. 13:4

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1 Q. Would you agree that having a low expenditure 13:4
2 per recipient is not good in terms of what it 13:4
3 indicates in terms of preventive care and 13:4
4 early intervention care? 13:4
5 A. Not necessarily. 13:4
6 Q. Okay. We would agree that Texas has not been 13:4
7 doing enough on preventive care and early 13:4
8 intervention care, agreed? 13:4
9 A. For the Medicaid recipients? Yes, I would 13:4
10 agree to that. It's one of the reasons we 13:4
11 went and are going to managed care. 13:4
12 Q. That's one reason -- strike that. 13:4
13 If -- one reason for that is that 13:4
14 Texas has not been spending enough per 13:4
15 Medicaid recipient to make available to them 13:4
16 preventive care and early intervention care, 13:4
17 would you agree with that? 13:4
18 A. Not necessarily. 13:4
19 Q. Okay. Texas is not doing enough -- not 13:4
20 spending enough per recipient to provide 13:4
21 early intervention and preventive care for 13:4
22 Medicaid recipients, are not doing enough -- 13:4
23 not spending enough for that purpose, 13:4
24 correct? 13:4
25 A. I'm not sure that spending is the issue as 13:4

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1 much as -- as where the priorities are made 13:4
2 in the distribution of how that spending is 13:4
3 done. I'm sorry. That's the distinction I'm 13:4
4 trying to make. 13:4
5 Q. So what your point is, is it's not the amount 13:4
6 of money spent. It's what value you're 13:4
7 getting for the money that's spent -- 13:4
8 A. Correct.
9 Q. -- in the way of services? 13:4
10 A. Correct. To a certain extent. I mean, at 13:4
11 some point more money would be helpful in 13:4
12 most cases. 13:4
13 Q. For example, if Texas Medicaid program was 13:4
14 spending $9 billion a year on Medicaid and 13:4
15 none of it was going for health care 13:4
16 services, all of it was being frittered away 13:4
17 in administrative costs and profits, that 13:4
18 wouldn't be very good. That would be very 13:4
19 inefficient and wasteful, correct? 13:4
20 A. Yes. 13:4
21 Q. Okay. You need to see what the $9 billion is 13:4
22 buying in terms of health care services. 13:4
23 A. Right. 13:4
24 Q. Right? So if you have a low dollar 13:4
25 expenditure per recipient, that doesn't 13:4

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1 indicate anything about whether your system 13:4
2 is efficient or effective unless you know 13:4
3 what the value is of the services you're 13:4
4 getting for those dollars, correct? 13:4
5 A. Yes, within some ranges I'm sure that exist. 13:4
6 Q. Right. 13:4
7 A. Right. 13:4
8 Q. So if you just look at the dollars per 13:4
9 recipient, it doesn't tell you anything about 13:4
10 whether there's waste or fraud or 13:4
11 inefficiency. 13:4
12 A. No, it doesn't. 13:4
13 Q. Okay. So in order to know whether low 13:4
14 dollars per recipient is good or bad, you've 13:4
15 got to look at the kind or value of services 13:4
16 being provided for the dollars, correct? 13:4
17 A. Generally, yes. 13:4
18 Q. It's not inconsistent to have a low dollar 13:4
19 expenditure per recipient and still have a 13:4
20 lot of fraud, waste and abuse. That can 13:4
21 happen, correct? 13:4
22 A. Yes, it could, theoretically. 13:4
23 Q. And indeed, you're familiar with the Texas 13:4
24 Performance Reviews, correct? 13:4
25 A. Yes, to some extent. 13:4

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1 Q. And it was part of your job and we talked 13:5
2 about before, I assume you've read those 13:5
3 Texas Performance Reviews? 13:5
4 A. To some extent, yes. 13:5
5 Q. Some you had responsibility to see if they 13:5
6 were implemented or not. I think it was 13:5
7 Breaking the Mold, for example, the first 13:5
8 one, correct? 13:5
9 A. My role was to participate in the legislative 13:5
10 process that considered which of those to do 13:5
11 or not do. I didn't have a role in 13:5
12 implementing it as an -- as an agency 13:5
13 administrator. 13:5
14 Q. In any -- in any event, you have read 13:5
15 portions or all of those TPRs over time -- 13:5
16 A. Over time, yes. 13:5
17 Q. -- in your various jobs with the state, 13:5
18 including as Medicaid director, correct? 13:5
19 A. Yes. 13:5
20 Q. And, in fact, the Texas Performance Reviews 13:5
21 have voiced significant concerns about 13:5
22 inefficiency and waste in the Medicaid 13:5
23 program, correct? 13:5
24 A. Yes. 13:5
25 Q. And that is not inconsistent with having a 13:5

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1 low dollar expenditure per recipient, 13:5
2 correct? 13:5
3 A. There's -- I don't see any direct correlation 13:5
4 between those two things. 13:5
5 Q. You can have a low dollar --
6 A. Is that your question? 13:5
7 Q. You can have a low dollar cost per recipient 13:5
8 and still have all of the concerns, all of 13:5
9 the inefficiency and waste that the Texas 13:5
10 Performance Reviews identify, correct? 13:5
11 A. Yes. 13:5
12 Q. In fact, what could -- Ms. Friedholm, if you 13:
13 took out the inefficiency, waste and fraud 13:
14 and all those things identified by the Texas 13:
15 Performance Reviews out of the Medicaid 13:5
16 dollars that are being spent, you could even 13:5
17 lower further the dollars spent per recipient 13:5
18 in Texas, correct? 13:5
19 A. I don't -- I can't answer that question 13:5
20 across the board about the Texas Performance 13:5
21 Review pieces. 13:5
22 Q. Okay. There were lots of recommendations 13:5
23 made in the Texas Performance Reviews on 13:5
24 changes that could be made to eliminate waste 13:5
25 or inefficiency ~~or~~ fraud or other kinds of 13:5

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1 things? 13:5
2 A. Yes. 13:5
3 Q. And they quantify what the savings would be 13:5
4 if, in fact, those recommendations were 13:5
5 adopted, did they not? 13:5
6 A. They gave their estimates, yeah. 13:5
7 Q. I understand they were -- they were 13:5
8 estimates. If, in fact, they -- those 13:5
9 recommendations were adopted and those monies 13:5
10 were saved, that would lower the dollar spent 13:5
11 per recipient in the State of Texas, correct? 13:5
12 A. If it was a legitimate recommendation, yes. 13:5
13 Q. Yes. We'll get to the TPRs in just a few 13:5
14 minutes. Let me move to another issue that 13:5
15 intrigued me, Ms. Friedholm, about your 13:5
16 testimony and that has to do with the Texas 13:5
17 Medicaid population. You testified about the 13:5
18 Harris County managed care pilot and that 13:5
19 there was a need -- that Texas -- you and the 13:5
20 state wanted to get providers from the 13:5
21 medical community who were treating Medicaid 13:5
22 recipients. Do you remember that? Strike it 13:5
23 and let me just ask it directly. 13:5
24 A. I'm sorry. I'm not referencing -- 13:5
25 Q. You're not recalling the testimony? And this 13:5

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1 was back in Monday, and I may not have had it 13:5
2 quite right, so let me ask it. Was there an 13:5
3 effort by the State of Texas to try to 13:5
4 encourage HMOs and managed care providers to 13:5
5 obtain a provider network from the community 13:5
6 in which Medicaid recipients live? 13:5
7 A. There is a provision that was passed in 1995 13:
8 requiring HMOs -- 13:
9 THE VIDEOGRAPHER: I'm sorry. I 13:
10 need to change videotape, please. Stand by. 13:
11 The time is 1:54. 13:
12 MR. HART: Take a break. 13:
13 (RECESS) 13:
14 THE VIDEOGRAPHER: Stand by, 14:
15 please. This is Tape 3 of the deposition of 14:
16 Ms. Friedholm. The time is 2:02 p.m. We're 14:
17 on the record. 14:
18 Q. Ms. Friedholm, before we -- we took the 14:
19 break, I think I had asked the question 14:
20 whether in connection with the Harris County 14:
21 managed care pilot there was an effort to 14:
22 encourage HMOs and managed care providers to 14:
23 obtain a provider network in the community 14:
24 where Medicaid recipients would be located? 14:
25 A. Well, there are regulations that require that 14:

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1 those providers be -- to clarify, because I 14:0
2 guess I misunderstood your question before. 14:0
3 You have to meet certain standards of 14:0
4 accessibility to the Medicaid recipients and 14:0
5 so you have to be within 30 miles or 45 14:0
6 minutes for a visit. 14:0
7 Q. Was this just merely an effort to comply with 14:0
8 regulations or was there also any interest on 14:0
9 the part of the state to have a provider 14:0
10 network familiar with the problems in the 14:0
11 Medicaid community? 14:0
12 A. It has been the state's interest, and in 1995 14:0
13 the legislature included in its Medicaid 14:0
14 related -- Medicaid managed care legislation 14:0
15 a requirement that significant traditional 14:0
16 providers be offered the opportunity to 14:0
17 participate in any of the HMOs. 14:0
18 Q. And what was the reason for that? 14:0
19 A. So that they would be included in the new 14:0
20 managed care project for at least the first 14:0
21 three years. That's the way it's stated. 14:0
22 Q. Was this -- was this an effort to benefit 14:0
23 recipients in terms of the kind and quality 14:0
24 of care they would receive or to benefit the 14:0
25 providers? 14:0

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1 A. Both. 14:0
2 Q. Okay. And how was it viewed that this would 14:0
3 benefit recipients, Medicaid recipients? 14:0
4 A. That they would continue to have as a choice 14:0
5 providers that they may have already 14:0
6 established some relationship with or who 14:0
7 they prefer to see. 14:0
8 Q. Was there any notion that those providers who 14:0
9 were in the community have better 14:0
10 understanding of the problems faced by the 14:0
11 Medicaid population? 14:0
12 A. Was there any notion? I think some of those 14:0
13 providers believe they have that. 14:0
14 Q. Was that -- was there any part of the purpose 14:0
15 of doing this the fact that it would benefit 14:0
16 recipients because there -- the providers in 14:0
17 that community would know the kinds of 14:0
18 problems they face in terms of health and 14:0
19 health risks and that sort of thing? 14:0
20 A. It was more a situation of being concerned 14:0
21 that they continue to be allowed to 14:0
22 participate and that new players in the 14:0
23 program did not exclude them because they 14:0
24 were not part of their regular commercial 14:0
25 network. 14:0

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1 Q. In addition, when Mr. Hay was asking you 14:0
2 questions on Monday, I think you testified 14:0
3 that the Medicaid population is different 14:0
4 from the general population with respect to 14:0
5 illnesses and diseases. Do you recall that? 14:0
6 A. Yes, basically. 14:0
7 Q. I mean, let me just ask. It is a fact that 14:0
8 the Medicaid population is different from the 14:0
9 general population in terms of the kinds of 14:0
10 illnesses and diseases they experience, 14:0
11 correct? 14:0
12 A. Yes. 14:0
13 Q. Like I think "Texas Medicaid in Perspective" 14:0
14 you make that point? 14:0
15 A. I don't recall. 14:0
16 Q. You don't recall. You mentioned in that 14:0
17 discussion with Mr. Hay sanitation as a 14:0
18 significant problem for some portions of the 14:0
19 Medicaid population. Do you recall that? 14:0
20 A. For people who live in certain parts of the 14:0
21 border area. He was asking about the border. 14:0
22 Q. And the border area, by the way, has a 14:0
23 significant influence on Texas Medicaid 14:0
24 expenditures, does it not? Let me ask it 14:0
25 this way. Strike that. 14:0

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1 The border population in terms of 14:0
2 the Medicaid population represents a good 14:0
3 percentage of total Medicaid dollars spent by 14:0
4 the State of Texas, correct? 14:0
5 A. I don't remember the dollars. I know it's a 14:0
6 proportion of the population. It's a 14:0
7 significant portion. 14:0
8 Q. It's a significant -- I'm not sure I 14:0
9 understood your answer. It's a significant 14:0
10 portion of the Medicaid dollars are being 14:0
11 spent in the border area, correct? 14:0
12 A. My answer was, I don't remember the dollars. 14:0
13 I remember that as a proportion of the 14:0
14 population, it's a significant number, but I 14:0
15 can't directly address the dollars. 14:0
16 Q. In terms of the total Medicaid population, do 14:0
17 you know what percentage of that population 14:0
18 is represented by Medicaid recipients in the 14:0
19 border area, the Valley area? 14:0
20 A. Not specifically the Valley, but south of San 14:0
21 Antonio and including El Paso, I believe it's 14:0
22 around 40 percent of the total population. 14:0
23 Q. And would you agree that that border 14:0
24 population is unique from most other areas of 14:0
25 the country in terms of the kinds of problems 14:0

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1 they face with respect to health care? 14:0
2 A. Unique in that they have some additional 14:0
3 problems that most Americans don't face. 14:0
4 Q. So would you agree that they're unique in 14:0
5 terms of the kinds of health care problems 14:0
6 they face? 14:0
7 A. I agree with what I just said. They have 14:0
8 many of the same, but they have a few extra. 14:0
9 Q. When you say "a few extra," let's probe 14:0
10 that. Diabetes? 14:0
11 A. Yes. 14:0
12 Q. Significant problem in the border area? 14:0
13 A. Yes, it is. 14:0
14 Q. Significant problem in the Hispanic 14:0
15 population? 14:0
16 A. Generally speaking. 14:0
17 Q. Hispanic population represents a very large 14:0
18 percentage of the total Medicaid population 14:0
19 in the State of Texas, correct? 14:0
20 A. Yes, it does. 14:0
21 Q. A more significant percentage of the Medicaid 14:0
22 population than of the general Texas 14:0
23 population, correct? 14:0
24 A. I'm not sure about that. 14:0
25 Q. Would you agree that diabetes causes all 14:0

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1 kinds of other health problems for those who 14:0
2 have it? 14:0
3 A. I'm not a medical doctor, but my 14:0
4 administrative experience was that it can 14:0
5 lead -- untreated and in some cases even 14:0
6 treated, can lead to further health problems. 14:0
7 Q. In sanitation likewise, poor sanitation can 14:0
8 be a significant problem in terms of causing 14:0
9 health problems for the community. 14:0
10 A. Yes. 14:0
11 Q. And sanitation is a -- I think you indicated 14:0
12 a particular problem in the border region 14:0
13 that we've been talking about? 14:0
14 A. In some of the Colonias areas that are along 14:0
15 the border, yeah. 14:0
16 Q. And what is it about poor sanitation that 14:1
17 leads to health -- illness, disease and other 14:1
18 health concerns? 14:1
19 A. Poor sanitation leads to infection and 14:1
20 disease. It's probably the single most 14:1
21 important thing a community can do. 14:1
22 Q. Can do to do what? 14:1
23 A. To improve the health. 14:1
24 Q. That is, to have good sanitation? 14:1
25 A. Yes. 14:1

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1 Q. That is, to improve the sanitation to improve 14:1
2 health? 14:1
3 A. Yes. 14:1
4 Q. Okay. Would you agree that poverty is 14:1
5 likewise an indicator or determinant of 14:1
6 disease? 14:1
7 A. Determinant of disease. I don't know that I 14:1
8 can agree to that. 14:1
9 Q. Okay. Would you agree that -- let me state 14:1
10 it differently -- that poverty is in itself a 14:1
11 risk factor for having worse -- 14:1
12 A. Yes. 14:1
13 Q. -- for having worse health? 14:1
14 A. Yes. 14:1
15 Q. Okay. And diet, of course, is a real risk 14:1
16 factor. If you don't have good diet, you're 14:1
17 more likely to have poor health, correct? 14:1
18 A. I -- I have seen and read and heard that. 14:1
19 I'm not in an expertise position to -- 14:1
20 Q. And would you agree --
21 A. -- to speak knowledgeably about that. 14:1
22 Q. In the Texas Medicaid population, would you 14:1
23 agree with me that particularly in the border 14:1
24 areas, diet is a real problem in those 14:1
25 areas? 14:1

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1 A. I don't know that I can speak knowledgeably 14:1
2 to that. 14:1
3 Q. Let me back up for a minute. As Medicaid 14:1
4 director, wasn't there some effort by the 14:1
5 state to determine what was causing illness 14:1
6 and disease and therefore expenditures by the 14:1
7 state for health care in the Medicaid 14:1
8 population? 14:1
9 A. There -- I can remember one specific instance 14:1
10 when there was an incidence, an usual number 14:1
11 of anencephalic children being born. It 14:1
12 wasn't necessarily Medicaid, but it was 14:1
13 particular to the border. 14:1
14 Q. Okay. And that was over in the 14:1
15 Brownsville -- that region of the Valley, 14:1
16 correct? 14:1
17 A. I think so. 14:1
18 Q. And it was -- there was an environmental 14:1
19 issue? 14:1
20 A. There were questions as to whether it was an 14:1
21 environmental issue. 14:1
22 Q. I guess I view issue and question the same. 14:1
23 But there was a question about whether the 14:1
24 cause was environmental or not, correct? 14:1
25 A. Yes. 14:1

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1	Q.	Would -- and aside from that, though --	14:1
2		setting aside that one instance, didn't --	14:1
3		are you aware of any effort by the state to	14:1
4		analyze what was causing poor health, illness	14:1
5		and disease in the Medicaid population in	14:1
6		order to try to improve the conditions	14:1
7		causing those poor health conditions?	14:1
8	A.	Not that I can think of, no.	14:1
9	Q.	Was there -- are you familiar with any	14:1
10		analysis of health care risks in the Medicaid	14:1
11		population?	14:1
12	A.	Any analysis of health care risks in the	14:1
13		Medicaid population?	14:1
14	Q.	Conducted by the State.	14:1
15	A.	No, not that I can think of.	14:1
16	Q.	For example -- let me give you an example.	14:1
17		Maybe this will refresh recollection. Strike	14:1
18		that.	14:1
19		Have you ever worked or serviced --	14:1
20		worked in the community, Medicaid community	14:1
21		to see firsthand, Ms. Friedholm, what the	14:1
22		life is like for Medicaid recipients?	14:1
23	A.	I have visited with Medicaid recipients. I	14:1
24		don't know that I can -- I mean, I visited	14:1
25		with Medicaid recipients.	14:1

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1 Q. When you visited with Medicaid recipients, 14:1
2 did you do it with the purpose of trying to 14:1
3 understand what they were experiencing in 14:1
4 terms of their life and health and illness or 14:1
5 was it just that you had a casual 14:1
6 conversation with Medicaid recipients? 14:1
7 A. We were discussing the program and issues 14:1
8 that they had about the program. 14:1
9 Q. Were these at public hearings? 14:1
10 A. Private and public. Private discussions and 14:1
11 public. 14:1
12 Q. Was it your effort in having these visits 14:1
13 with Medicaid recipients to understand what 14:1
14 was causing their health care expenditures 14:1
15 and their need for Medicaid? 14:1
16 A. The purpose was more specifically to see what 14:1
17 their experience was being of the health care 14:1
18 system and if there were barriers or problems 14:1
19 or difficulties that they were -- they were 14:1
20 experiencing in -- in getting health care -- 14:1
21 Q. So --
22 A. -- be it Medicaid or other. 14:1
23 Q. So the purpose was primarily to find out if 14:1
24 they were having difficulty in access to 14:1
25 Medicaid or other health and human services? 14:1

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1	A.	Yes.	14:1
2	Q.	It was not to find out what was -- what their	14:1
3		life-style was like or what their health	14:1
4		problems were; is that correct?	14:1
5	A.	Yes.	14:1
6	Q.	Okay. Was there ever any study done by --	14:1
7		that you're aware of by the state, Medicaid	14:1
8		or health and human service agencies, to	14:1
9		understand what the health problems were of	14:1
10		Medicaid recipients in the State of Texas?	14:1
11	A.	There was a study done to understand the --	14:1
12		the health needs and the nutritional needs of	14:1
13		low-income Texas which -- Texans which	14:1
14		included a substantial number of the welfare	14:1
15		and Medicaid recipients.	14:1
16	Q.	When was that study done?	14:1
17	A.	Mid '80s.	14:1
18	Q.	Do you remember the title?	14:1
19	A.	No.	14:1
20	Q.	Do you remember who did the study?	14:1
21	A.	The Senate -- there was a special senate	14:1
22		committee. Select Committee on Hunger I	14:1
23		believe was the title of the group.	14:1
24	Q.	Was it primarily devoted to nutritional	14:1
25		issues --	14:1

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1 A. Yes.
2 Q. -- that is, diet and access to food? 14:1
3 A. Yes. 14:1
4 Q. Did it deal with any of the other issues 14:1
5 related to health care problems and concerns 14:1
6 in low income or Medicaid populations? 14:1
7 A. Not that I know of. 14:1
8 Q. Okay. Are you aware of any other study other 14:1
9 than that one study that has addressed or 14:1
10 attempted to evaluate the health care 14:1
11 concerns or problems of Medicaid recipients 14:1
12 in Texas? 14:1
13 A. The health care concerns? 14:1
14 Q. Health care problems or concerns. 14:1
15 A. Beyond the access -- 14:1
16 Q. Beyond access. 14:1
17 A. -- work? No, not that I can think of. 14:1
18 Q. Okay. Are you aware of whether alcohol and 14:1
19 drug use is a problem in the Medicaid 14:1
20 community? 14:1
21 A. In a very general way I'm aware of that it's 14:1
22 a concern. 14:1
23 Q. And by concern, are we talking about drug use 14:1
24 and excessive alcohol use? 14:1
25 A. Well, with regard, for example, to the 14:1

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1 pregnant women population and any alcohol 14:1
2 use. But particularly -- what you said as 14:1
3 well as any alcohol use for that. 14:1
4 Q. Would you agree that excessive alcohol use 14:1
5 and drug use is more of a problem in the 14:1
6 Medicaid population than it is in the general 14:1
7 population in Texas? 14:1
8 A. I don't know that I can say that. 14:1
9 Q. What efforts have been made by the state to 14:1
10 educate Medicaid recipients with respect to 14:1
11 proper nutrition and diet? 14:1
12 A. An attempt to make sure that particularly 14:1
13 pregnant women and -- and then their 14:1
14 resulting newborns are in the WIC program 14:1
15 where they get nutritional counseling and 14:1
16 assistance. 14:1
17 Q. What program? 14:1
18 A. WIC. 14:1
19 Q. Can you tell me what WIC stands for? 14:
20 A. Women, Infant and Children Supplemental 14:1
21 Feeding Program. RI -- I mean, WIC is its 14:1
22 short name. And then the -- one of the 14:
23 reasons we liked managed care was to try to 14:
24 see that that is encouraged through that 14:
25 relationship of prevention and -- and primary 14:

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1 care provider, and there are newsletters and 14:
2 written mailers that go out to Medicaid 14:
3 recipients that will from time to time have 14:
4 specific -- well, each month that they'll 14:
5 have some kind of informative piece, but 14:
6 frequently that has to do with nutrition or 14:
7 breast feeding versus -- again, I think this 14:
8 is more for the pregnant women -- breast 14:
9 feeding versus bottle feeding and those kinds 14:
10 of issues. 14:
11 Q. And this goes out on a monthly basis? 14:
12 A. I believe it's monthly -- 14:
13 Q. Does it go to --
14 A. -- for pregnant women. 14:
15 Q. Oh, it only goes to pregnant women? 14:
16 A. Yes. 14:
17 Q. Is there a newsletter or mailer that goes out 14:
18 to the other portions of the Medicaid 14:
19 population? 14:
20 A. Not on a regular basis that I'm aware of. 14:
21 Q. Is there any that goes out on an irregular 14:
22 basis? 14:
23 A. Just time to time there would be mailers put 14:
24 into mailings that go out to the recipients. 14:
25 Q. Were any of those mailings to other than 14:

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1 pregnant women for the purpose of trying to 14:2
2 encourage Medicaid recipients to improve 14:2
3 their diet or decrease alcohol or drug use? 14:2
4 A. I'm not sure I can say what it was about. 14:2
5 Q. Was there -- was -- are you aware of any 14:2
6 effort aside from the WIC program for 14:2
7 pregnant women -- any effort by the state to 14:2
8 try to address the core problems of Medicaid 14:2
9 recipients in terms what was causing illness 14:2
10 and disease? 14:2
11 A. Well, there are extensive public health 14:2
12 efforts that are not targeted only to 14:2
13 Medicaid, but that are available across the 14:2
14 state that the Health Department runs 14:2
15 frequently in conjunction with local health 14:2
16 departments.
17 Q. And that is not directed just at the Medicaid 14:2
18 population. It's directed at all 14:2
19 low-income -- 14:2
20 A. Right.
21 Q. -- population? 14:2
22 A. Right. 14:2
23 Q. Do you know if any of those efforts have 14:2
24 included efforts to improve diet, exercise, 14:2
25 decrease alcohol use or drug use in this 14:2

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1 population, Medicaid population or even the 14:2
2 low-income population? 14:2
3 A. There are billboards and public service 14:2
4 announcements and things like that and they 14:2
5 are available to anybody to see. 14:2
6 Q. Have any of those, to your knowledge, ever 14:2
7 addressed the issue of smoking? 14:2
8 A. There has been a public campaign against 14:2
9 smoking that the Health Department has run 14:2
10 for a couple of years at least. 14:2
11 Q. Starting when, do you know? 14:2
12 A. A couple of years at least. I really don't 14:2
13 know. 14:2
14 Q. You're talking about the last couple of 14:2
15 years? 14:2
16 A. Yeah. 14:2
17 Q. Not couple of years back in the '80s or '70s. 14:2
18 You're talking about in --
19 A. No, no. In the -- well, there may have 14:2
20 been. I'm not familiar with those, but this 14:2
21 has been in the -- in the '90s. 14:2
22 MR. FENNELL: Please mark this as
23 the next exhibit.
24 (Deposition Exhibit No. 10 14:2
25 (marked for identification.

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1 Q. Ms. Friedholm, let me hand you what's been 14:2
2 marked for identification as Friedholm 14:2
3 Exhibit Number 10, which is "Texas Medicaid 14:2
4 in Perspective," Second Edition, dated 14:2
5 January 1997, and ask you if you can identify 14:2
6 that. Let me ask it this way: Is that a 14:2
7 true and correct copy of that document? 14:2
8 A. I have no way to know if it's a true and 14:2
9 correct copy. It appears to be a copy. 14:2
10 Q. You want to leaf through it and let me know 14:2
11 if based on -- you participated in the 14:2
12 preparation of the first version, I guess; is 14:2
13 that correct?
14 A. Yes. 14:2
15 Q. And you have read this version, correct? 14:2
16 A. Yes. 14:2
17 Q. If you could just look through it and let me 14:2
18 know whether it appears to you to be a true 14:2
19 and correct copy. 14:2
20 A. It appears to be. 14:2
21 Q. There is a page in this -- it's like two 14:2
22 pages or three pages back, Ms. Friedholm. It 14:2
23 doesn't have a page number, but it says "The 14:2
24 Medicaid Numbers." 14:2
25 A. Yes. 14:2

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1 Q. Do you see that? There is a statement like 14:2
2 that is four lines from the bottom, that says 14:2
3 that "The number of childless, nonelderly, 14:2
4 nondisabled, nonpregnant Medicaid-eligible 14:2
5 adults is zero." 14:2
6 A. Uh-huh. 14:2
7 Q. Is that right? 14:
8 A. Yes. 14:
9 Q. I'm not sure I understand that and I want to 14:
10 ask some questions about it. And I know this 14:
11 relates to the issue of eligibility. Is it 14:
12 correct that a large percentage of the 14:
13 Medicaid population are pregnant females? 14:
14 A. No. 14:
15 Q. Do you know what percentage of the Medicaid 14:
16 population are represented by pregnant 14:
17 females? 14:
18 A. Well, I don't know a percentage, but 155, 14:
19 160,000 births per year are paid for by 14:
20 Medicaid, assuming one pregnant woman per 14:
21 birth. 14:
22 Q. Fair assumption. 14:
23 A. Fair -- fairly fair. 14:
24 Q. Not quite fair. 14:
25 A. Yeah. So I can't work a percentage in my 14:

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1 head. 14:2
2 Q. Children represent -- let me ask it this 14:2
3 way. Would you agree that in terms of the 14:2
4 total Medicaid costs in a given year, that 14:2
5 pregnancy-related costs are a significant 14:2
6 percentage of those costs? 14:2
7 A. Oh, boy. I can't remember what the costs of 14:2
8 the pregnancy are anymore. It's -- it's not 14:2
9 insignificant. It is not among the largest 14:2
10 expenditures, but it's a -- you know, it's a 14:2
11 substantial amount of money. 14:2
12 Q. But your understanding, it is not the largest 14:2
13 percentage of total Medicaid expenditures? 14:2
14 A. For pregnancy? 14:2
15 Q. Yes. 14:2
16 A. No. 14:2
17 Q. Okay. Children, I think it says here, 14:2
18 actually represent about 57 percent -- it's 14:2
19 right about in the middle of the page -- of 14:2
20 Medicaid recipients, correct? 14:2
21 A. Yes. 14:2
22 Q. Do you know what percentage of the Medicaid 14:2
23 population is represented by nursing home 14:2
24 residents? 14:2
25 A. Nursing home only? 14:2

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1 Q. Let's say the elderly, in excess of 65. 14:2
2 A. About 12 percent -- 11 or 12 percent. The 14:2
3 elderly over 65. 14:2
4 Q. Right. So 69 percent of the -- of the 14:2
5 Medicaid population is represented by 14:2
6 children. I assume children -- is that under 14:2
7 16 or under 18? 14:2
8 A. 18, I believe. 14:2
9 Q. Okay. So 69 percent of the Texas Medicaid 14:2
10 population is either represented by children 14:2
11 under 18 or those in excess of 65 years old. 14:2
12 A. Yes. 14:2
13 Q. Okay. And some additional percentage is 14:2
14 represented by pregnant females? 14:2
15 A. Right. 14:2
16 Q. Whatever it turns out to be? 14:2
17 A. Whatever that is, yes. 14:2
18 Q. Can you tell me what percent of the Medicaid 14:2
19 population is in the age group of 35 to 64 14:2
20 who are not pregnant and not disabled? 14:2
21 A. I can't tell you that specifically a number, 14:2
22 but it would be the head of households of 14:2
23 AFDC basically, which is now TANF, but the 14:2
24 welfare assistance program. It would be the 14:2
25 head of household number. 14:2

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1 Q. Do you know if that's a big number or a small 14:2
2 number? 14:2
3 A. It's around 250,000, but it's gone down 14:2
4 recently, so I'm not sure that I know. 14:2
5 Q. Are you talking about if we just look at the 14:2
6 adults, the heads of households of AFDC? 14:2
7 A. You asked me between, say, 35 and 64? 14:2
8 Q. Right. 14:2
9 A. Well, then, reduce that number some because 14:2
10 35 is too low. There are a lot of AFDC 14:2
11 mothers who are younger than 35. 14:2
12 Q. Right. 14:2
13 A. But that is an approximate number. 14:2
14 Q. Okay. Do you know what percent of children 14:2
15 under the years of 18 years old suffer from 14:2
16 smoking-related diseases? 14:2
17 A. No. 14:2
18 Q. Do you have any idea what that percentage 14:2
19 would be? 14:2
20 A. No. 14:2
21 MR. HART: Did you say 18? 14:2
22 MR. FENNELL: Yes. 14:2
23 Q. What about pregnant females? Do you know 14:2
24 what percentage would be suffering from 14:2
25 smoking-related diseases? 14:2

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1 A. No. 14:2
2 Q. Do you know what percentage of the Medicaid 14:2
3 population suffers from smoking-related 14:2
4 diseases or illnesses? 14:2
5 A. No, I don't. 14:2
6 Q. Do you have any idea what percentage? 14:2
7 A. No. 14:2
8 Q. I mean, one percent, two percent, 20 14:2
9 percent? You have no idea? 14:3
10 A. No. 14:3
11 Q. You have no idea, correct? 14:3
12 A. No -- correct. 14:3
13 Q. You do have an idea?
14 A. Correct. Excuse me. I have no idea. 14:3
15 Q. Let me ask you a few questions, 14:3
16 Ms. Friedholm, about the managed care -- 14:3
17 strike that. 14:3
18 Was there -- in your experience as 14:3
19 Texas' director of Medicaid and your prior 14:3
20 positions with the state government, are you 14:3
21 aware of any effort to determine the 14:3
22 contribution of smoking to the health care 14:3
23 costs incurred in Texas in the Medicaid 14:3
24 program? 14:3
25 A. No. 14:3

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1 Q. Was there ever any discussion about 14:3
2 attempting to determine the effect of smoking 14:3
3 on the health of Medicaid recipients? 14:3
4 A. Not that I'm aware of. 14:3
5 Q. Do you know what the prevalence is of smoking 14:3
6 and the Medicaid population as compared to 14:3
7 the general population? 14:3
8 A. No. 14:3
9 Q. Was there any effort to determine the 14:3
10 prevalence of smoking in the Medicaid 14:3
11 population versus either in absolute terms or 14:3
12 as compared to any other segment of the 14:3
13 population? 14:3
14 A. Not to my knowledge. 14:3
15 Q. And aside from that campaign that you talked 14:3
16 about in the last couple of years, you're not 14:3
17 aware of any effort by the state to 14:3
18 discourage smoking in the Medicaid 14:3
19 population, correct? 14:
20 A. Correct. 14:
21 Q. With respect to managed care, is there any 14:3
22 question in your mind, Ms. Friedholm, that 14:3
23 managed care has been successful in the area 14:
24 of Medicaid? 14:
25 A. Yes, there's some question. 14:

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1 Q. Tell me all -- you gave us all the advantages 14:3
2 of Medicaid or managed care when you were 14:3
3 responding to Mr. Hay's questions. Can you 14:3
4 tell me what negatives you believe exist with 14:3
5 managed care, if any? 14:3
6 A. First of all, I didn't tell you all of the 14:3
7 benefits of managed care before, just hit 14:3
8 highlights. 14:3
9 Q. Let me stay on negatives for a moment. I'll 14:3
10 come back to that. 14:3
11 A. I just wanted to state for the record. For 14:3
12 the down side, there is obviously the 14:3
13 possibility that individuals -- that there 14:3
14 could be financial incentives for HMOs to 14:3
15 discourage the provision of care so as to 14:3
16 maximize their profits. 14:3
17 Q. Okay. Any others? 14:3
18 A. There is the possibility that it can 14:3
19 undermine the publicly-funded safety net 14:3
20 system that the state has that cares for 14:3
21 other uninsured people by moving Medicaid 14:3
22 recipients away from those public systems and 14:3
23 into private systems and thus reduce the 14:3
24 availability of Medicaid as a revenue base 14:3
25 for providers who see other patients. 14:3

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1 Q. Can you state that in different terms to me? 14:3
2 I'm sorry. I missed it. 14:3
3 A. There is a concern that by moving Medicaid 14:3
4 into managed care, that that movement will 14:3
5 include shifting Medicaid patients away from 14:3
6 our public safety net system of public 14:3
7 hospitals and clinics where they are cared 14:3
8 for and into provider systems that do not 14:3
9 take other publicly-funded individuals. 14:3
10 Q. And how is that a disadvantage? 14:3
11 A. It can upset the Disproportionate Share 14:3
12 Program. It can lead to an undercutting of 14:3
13 revenue stream that those public institutions 14:3
14 have built their staffs for. 14:3
15 Q. Okay. I want to come back to that. Is 14:3
16 this -- for example, when you've been 14:3
17 consulting with the City of Austin, that's 14:3
18 the problem that they are experiencing with 14:3
19 their own hospital and their facilities, 14:3
20 correct? 14:3
21 A. No. My consulting with them has to do with 14:3
22 the public health clinics solely and has to 14:3
23 do with changes in demand as well as funding 14:3
24 revenue streams such as Medicaid. 14:3
25 Q. But the problem ~~is~~ that it is the same 14:3

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1 problem you're identifying here, and that is 14:3
2 that with managed care there will be less 14:3
3 demand for those public health facilities 14:3
4 resulting in decreased revenue given the 14:3
5 current staffing levels that they are at in 14:3
6 those facilities, correct? 14:3
7 A. It is a possibility. 14:3
8 Q. So their concern is exactly the concern 14:3
9 you're identifying as that? 14:3
10 A. An unintended -- well, they have a wide range 14:3
11 of concerns. This is one of them. 14:3
12 Q. One of them? 14:3
13 A. Yeah. 14:3
14 Q. Okay. And the problem there, I take it, is 14:3
15 that these public facilities are overstaffed, 14:3
16 then, for the demand for their facilities, is 14:3
17 the bottom line, in regard to this one 14:3
18 problem. That is, they're having less demand 14:3
19 for their services and they've geared up with 14:3
20 all the staff for a higher level of services 14:3
21 than they are needing to provide. 14:3
22 A. Well, if a shift occurred, they would have to 14:3
23 downsize. 14:3
24 Q. Right. And that's a disadvantage. 14:3
25 A. Well, it is to the whole public system, yes. 14:3

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1 Q. Anything else other than those two concerns 14:3
2 you've identified as potential disadvantages? 14:3
3 A. Those are two -- the two big ones. I'm not 14:3
4 thinking of any others. 14:3
5 Q. Okay. Let's go to the first one for a 14:3
6 minute, the possibility that HMOs would 14:3
7 discourage provision of care to maximize 14:3
8 profits. They would be discouraged to 14:3
9 provide care so they could maximize their 14:3
10 profits. 14:3
11 A. Yes. 14:3
12 Q. If they think like you think, that is, that 14:3
13 preventive care and early intervention saves 14:3
14 money in the long run, they wouldn't do that, 14:3
15 agreed? 14:3
16 A. Yes. 14:3
17 Q. If they are enlightened in the sense of 14:3
18 understanding the benefits of preventive 14:3
19 care, they will provide quality care up front 14:3
20 and save themselves money in the long run, 14:3
21 agreed? 14:3
22 A. If they keep that patient for the long run, 14:3
23 yes. 14:3
24 Q. Yes. And, in fact, the experience has been 14:3
25 that this possibility of a lowering of 14:3

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1 quality of care has not happened; isn't that 14:3
2 correct?
3 A. In the Medicaid program? 14:3
4 Q. In the Medicaid program. 14:3
5 A. I don't know that I've seen enough analysis 14:3
6 to be able to say one way or the other. 14:3
7 Q. In terms of the pilots in Texas -- 14:3
8 A. Right. 14:3
9 Q. -- what has been the experience in terms of 14:3
10 the quality of care, that is, access to 14:3
11 preventive care and quality of care for 14:3
12 Medicaid recipients? 14:3
13 A. At least in the early studies that I saw and 14:3
14 upon which we based our recommendations to 14:3
15 move forward, it was an increase in some of 14:3
16 those early preventive type services such as 14:3
17 doctor office visits, immunizations. 14:3
18 Q. You did not see any decrease in the quality 14:3
19 of care in those Texas pilots at least to 14:3
20 date, correct? 14:3
21 A. Well, I can't say to date, but of the things 14:3
22 that I saw when I was Medicaid director, we 14:3
23 were not getting any, you know, indication of 14:3
24 that early on. 14:3
25 Q. No indication of any decrease in quality of 14:3

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1 care; is that correct? 14:3
2 A. Any decrease, yes. 14:3
3 Q. Do you know based on the experience of other 14:3
4 states what the experience has been in terms 14:3
5 of quality of care in Medicaid managed care 14:3
6 programs? 14:3
7 A. It's varied. 14:3
8 Q. Can you cite an example of a state which has 14:3
9 had decreases in quality of care in their 14:3
10 Medicaid managed care programs? 14:3
11 A. There have been reports of studies of states 14:3
12 where, without sufficient oversight and 14:3
13 evaluation, that there were complaints of 14:
14 being discouraged from or that barriers were 14:
15 established by HMOs to keep people from 14:
16 really being able to access health care in a 14:
17 timely -- 14:
18 Q. Which states?
19 A. -- fashion. 14:
20 Q. Which states? 14:
21 A. I can't remember anymore. 14:
22 Q. Do you know -- can you identify any of those 14:
23 reports by name? 14:
24 A. No. I'm sorry. 14:
25 Q. You preface that by saying without sufficient 14:

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1 oversight and evaluation. Is that to mean 14:4
2 that if proper oversight and evaluation is 14:4
3 done by the state, that this problem or 14:4
4 potential problem can be avoided? 14:4
5 A. That's my belief. I don't know that I can 14:4
6 prove that, but that's my belief. 14:4
7 Q. And based -- let me ask you your personal 14:4
8 view on this. Is it your personal view that 14:4
9 there would be a sacrifice of quality of care 14:4
10 or an improvement of quality of care with 14:4
11 managed care properly run in the Medicaid 14:4
12 program? 14:4
13 A. Improvement. 14:4
14 Q. So all that's a -- although that's a 14:4
15 potential negative of managed care, it's not 14:4
16 one that you agree with, correct? 14:4
17 A. I agree that it is a potential. 14:4
18 Q. But not a real concern, correct? 14:4
19 A. It is a very real concern -- 14:4
20 Q. It is not one --
21 A. -- but it is one that can be addressed. 14:4
22 Q. And therefore not be a concern? 14:4
23 A. It doesn't have to be a concern. It doesn't 14:4
24 have to be a probability. 14:4
25 Q. Now, is the same thing true with your second 14:4

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1 potential disadvantage of managed care, that 14:4
2 is, that if it's properly addressed, you can 14:4
3 avoid the hardship of this transition to 14:4
4 managed care? 14:4
5 A. I think the jury is out. I'm not sure that I 14:4
6 know the answer to that question. 14:4
7 Q. I was going to say, the jury is out, but how 14:4
8 about Ms. Friedholm? Are you out on this 14:4
9 issue still or have you resolved it in your 14:4
10 own mind whether this problem can be 14:4
11 addressed -- and solved, not just addressed? 14:4
12 A. Well, it can be addressed. I don't know that 14:4
13 it will be solved. 14:4
14 Q. I assume that in the balancing of the 14:4
15 advantages and disadvantages of Medicare -- 14:4
16 of managed care that you as Texas Medicaid 14:4
17 director decided that the advantages far 14:4
18 outweighed the potential disadvantages. 14:4
19 A. Well, that was the basis of my decision to 14:4
20 recommend pursuing managed care. 14:4
21 MR. FENNELL: Can we take a 14:4
22 10-minute break so I can -- 14:4
23 MR. HART: Sure. Off the record. 14:4
24 THE VIDEOGRAPHER: The time is 2:43 14:4
25 p.m. Going off the record. 14:4

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1 (RECESS)
2 THE VIDEOGRAPHER: Stand by, 14:5
3 please. The time is 2:53 p.m. We're on the 14:5
4 record. 14:5
5 Q. Ms. Friedholm, in Exhibit 10, which is "Texas 14:5
6 Medicaid in Perspective," both in the 14:5
7 updated Second Edition which you have before 14:5
8 you and in the First Edition that you were 14:5
9 involved in preparing, there was significant 14:5
10 amount of time or pages devoted to the health 14:5
11 care industry in Texas. Do you recall that? 14:5
12 A. Generally, yes. 14:5
13 Q. And the notion was, I, guess that health care 14:5
14 is big business in the State of Texas. 14:5
15 A. Well, the notion -- the reason -- I don't 14:5
16 understand what you mean by "the notion." 14:5
17 Q. Well, is it a fact that health care is a big 14:5
18 industry in the State of Texas? 14:5
19 A. Yes. 14:5
20 Q. In terms of numbers of workers, contribution 14:5
21 to gross national product, it's big business 14:5
22 in Texas. 14:5
23 A. Yes. 14:5
24 Q. You in some testimony in response to Mr. Hay 14:5
25 suggested, and I just want to find out from 14:5

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1 you whether it is the case, that an 14:5
2 impediment to adoption of managed care has 14:5
3 been the influence of this health care 14:5
4 industry in the State of Texas; is that 14:5
5 correct?
6 A. That there are segments of the health care 14:5
7 industry that have been less than excited 14:5
8 about moving to managed care at all. 14:5
9 Q. Right. 14:5
10 A. And that includes Medicaid. 14:5
11 Q. And as a result of them being less excited 14:5
12 than they might otherwise be for managed 14:5
13 care, they have opposed efforts by the state 14:5
14 to adopt managed care? 14:5
15 A. Yes. 14:5
16 Q. And they've opposed early efforts by the 14:5
17 state to adopt managed care? 14:5
18 A. Yes. 14:5
19 Q. And they have influenced the legislature with 14:5
20 respect to its efforts to adopt managed care 14:5
21 proposals, correct? 14:5
22 A. They have had influence on the nature of 14:5
23 those proposals. They have not stopped those 14:5
24 proposals. 14:5
25 Q. Did they delay those proposals? 14:5

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1 A. Not in the legislative process. 14:5
2 Q. Did they delay them at all, whether in the 14:5
3 legislative process or in the state's 14:5
4 executive branch process? 14:5
5 A. Well, I've already stated that implementation 14:5
6 of the first two projects took longer than 14:5
7 had been anticipated, and a key factor in 14:5
8 that was not having sufficient providers 14:5
9 signing up to participate. 14:5
10 Q. Well, I'm not talking about providers signing 14:
11 up. I'm talking about providers, that is, 14:
12 doctors and hospitals, resisting managed care 14:
13 in the state and therefore influencing the 14:
14 state, whether the executive branch or the 14:
15 legislative branch, to delay or change 14:
16 proposals to adopt managed care. 14:5
17 A. Change. I can't -- I can't recall of a 14:
18 situation as an example of delay. 14:
19 Q. Has there been a reluctance on the part of 14:
20 the state to move to managed care by reason 14:
21 of the influence of the health care industry 14:5
22 in the state? 14:
23 A. Let me correct something I just said. There 14:
24 was on the part of providers, both hospitals 14:
25 and physicians, a reluctance to participate 14:

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1 in one of the managed care projects, which 14:5
2 did cause a delay. Okay. Now, you asked me 14:5
3 -- 14:5
4 MR. FENNELL: Why don't you read
5 the question back. 14:5
6 THE WITNESS: I apologize. 14:5
7 MR. FENNELL: That's all right.
8 (The reporter read back
9 (the requested testimony.
10 Q. Let me rephrase it. Was -- has there been a 14:
11 reluctance on the part of the state to move 14:
12 to managed care by reason of the influence of 14:
13 the health care industry in the state? 14:
14 A. In terms of official actions taken, since 14:
15 1991 and when it first became a serious 14:
16 proposal for Medicaid to take on managed care 14:
17 or move to managed care or at least pilot 14:
18 managed care, the industry has influenced the 14:
19 nature of how the state has carried it out, 14:
20 but it has not slowed down or made it more 14:
21 reluctant, in my opinion. 14:
22 Q. What about prior to 1991? 14:
23 A. I cannot recall any serious discussion of 14:
24 managed care with Medicaid prior to that 14:
25 year, 1990, '91 period, when TPR was being 14:

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1 developed. 14:5
2 Q. And do you know whether the fact that there 14:5
3 wasn't any serious discussion was in part due 14:5
4 to the influence of the health care industry 14:5
5 in the state? 14:5
6 A. Well, influence only indirectly in that there 14:5
7 wasn't much in the state at all, period. 14:5
8 Q. Again, you're talking about provider network? 14:5
9 A. I'm just talking about in general. Managed 14:5
10 care as a delivery system was not very widely 14:5
11 used in Texas in the '80s or '70s. 14:5
12 Q. I understand it wasn't, and I'm looking for 14:5
13 the reason that it wasn't and asking whether 14:5
14 one of the reasons -- I understand you've 14:5
15 testified about some reasons, but whether one 14:5
16 of the reasons was the influence of the 14:5
17 health care industry in the State of Texas. 14:5
18 It didn't want managed care. It resisted 14:5
19 managed care. 14:5
20 A. Yes. 14:5
21 Q. And therefore, the state legislature and 14:5
22 executive branch didn't move to managed care 14:5
23 because of the influence of that industry in 14:5
24 the state; is that correct? 14:5
25 A. To my knowledge, it was never even considered 14:5

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1 by the state. 14:5
2 Q. And was it not considered by reason of the 14:5
3 influence of the health care industry, if you 14:5
4 know?
5 A. I don't know that I can really directly 14:5
6 answer that. 14:5
7 Q. You don't know whether there was -- you don't 14:5
8 know what was influencing or not influencing 14:5
9 the move to managed care prior to 1991 or the 14:5
10 consideration of managed care prior to 1991; 14:5
11 is that correct?
12 A. That's correct. 14:5
13 Q. You do understand that there was 14:5
14 recommendations to move to managed care in 14:5
15 the late 1970s and in 1980 -- and in the mid 14:5
16 1980s? 14:5
17 A. No, I was not aware of that. In Texas? 14:5
18 You're speaking of Texas? 14:5
19 Q. In Texas. 14:5
20 A. I'm not aware of any that came to my 14:5
21 attention. 14:5
22 Q. Do you ever read or are you familiar with a 14:5
23 document called "Potential in the Patchwork"? 15:0
24 A. A long time ago, yes. 15:0
25 Q. Do you recall it making recommendations that 15:0

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1 Texas move to managed care in Medicaid? 15:0
2 A. No. 15:0
3 Q. You did read the document? 15:0
4 A. That document was done in 1980, I believe. 15:0
5 Q. Right. 15:0
6 A. Yes. I read it about 1980. 15:0
7 Q. I will not ask you the details of that 15:0
8 document. 15:0
9 A. Please don't. 15:0
10 Q. Do you know who participated in that study, 15:0
11 "Potential in the Patchwork"? 15:0
12 A. It was a citizen group appointed by the 15:0
13 legislature, I believe, by the lieutenant 15:0
14 governor and speaker. 15:0
15 Q. Included Ann Richards, among others? 15:0
16 A. She was a county commissioner, yes. 15:0
17 Q. When you read that document -- I understand 15:0
18 it was a long time ago -- did you have any 15:0
19 reason to doubt the reliability and accuracy 15:0
20 of what was reported? 15:0
21 A. No. 15:0
22 Q. The Arizona experience, let me just move to 15:0
23 that. I'm going to jump around so maybe we 15:0
24 can move forward more quickly. My 15:0
25 recollection is that was implemented in 1981, 15:0

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1 correct? 15:0
2 A. I believe so. 15:0
3 Q. And I believe you testified in response to 15:0
4 Mr. Hay's questions that there were -- the 15:0
5 first few years were -- I think your term was 15:0
6 rocky? 15:0
7 A. Yes. 15:0
8 Q. Okay. Can you tell me what you mean by their 15:0
9 experience? 15:0
10 A. They contracted out the development and the 15:0
11 administration of the program to a private 15:0
12 company that fell flat on its face and the 15:
13 state had to go back in and take it over and 15:
14 re -- completely redesign it and start over 15:0
15 again, and they lost a handful of years in 15:0
16 there. 15:0
17 Q. Was that the only problem -- it's a big 15:0
18 problem, don't get me wrong, but was that the 15:0
19 only problem that they experienced in those 15:
20 first couple of years? 15:
21 A. That's the only problem I recall learning 15:0
22 about. 15:
23 Q. But was -- here's where I'm going. Was there 15:
24 any problem with a provider base, that is, an 15:
25 HMO or managed care provider base, in 1981 15:

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1 that Arizona experienced? 15:0
2 A. I don't know the answer to that. 15:0
3 Q. Okay. And by contracting out the 15:0
4 administration of the program, you're talking 15:0
5 about the overseers of the managed care or 15:0
6 HMO providers, correct? 15:0
7 A. As I recall, they contracted out the whole 15:0
8 thing. Said develop it and do it. 15:0
9 Q. Okay. Now, when you said first few years, 15:0
10 they solved this problem by what year? 15:0
11 A. I don't remember. It was a couple of years 15:0
12 later. 15:0
13 Q. 1983, 1984? 15:0
14 A. Yes. 15:0
15 Q. And has it been successful ever since? 15:0
16 A. It's my understanding. 15:0
17 Q. And no problem with HMO or managed care 15:0
18 provider or provider base in Arizona, 15:0
19 correct? 15:0
20 A. Correct. To my knowledge. 15:0
21 Q. Do you know if in the first year they went 15:0
22 out, Arizona, to seek providers, HMO and 15:0
23 managed care providers, whether they had 15:0
24 difficulty finding an adequate base? 15:0
25 A. No, I don't know. 15:0

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1 Q. Would you have expected that the first year 15:0
2 when they indicated their initial interest 15:0
3 that there might not have yet been a sizable 15:0
4 HMO and managed care base in the first year? 15:0
5 A. I don't know enough about the Arizona general 15:0
6 system to know whether or not they were more 15:0
7 like California than they were like Texas and 15:0
8 that California had an extensive managed care 15:0
9 base. 15:0
10 Q. Right.
11 A. So I -- I don't know how to answer the 15:0
12 question. 15:0
13 Q. I mean, would you agree with me that until 15:0
14 interest is indicated by a state -- strike 15:0
15 that. 15:0
16 Until interest is indicated by a 15:0
17 state, there may not yet be a fully developed 15:0
18 HMO and managed care infrastructure? 15:0
19 A. Oh, yes, there can be. 15:0
20 Q. There can be. I'm talking about commercial 15:0
21 HMOs and managed care? 15:0
22 A. Yes. 15:0
23 Q. In Texas, let's take 1985, was there a 15:0
24 well-developed commercial HMO and managed 15:0
25 care provider base in the metropolitan areas 15:0

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1 of Texas? 15:0
2 A. Not to my knowledge. 15:0
3 Q. How about 1988? Was it developed by that 15:0
4 time in Texas in the metropolitan areas? 15:0
5 A. There's -- you can't speak of the 15:0
6 metropolitan areas as a group. As I recall, 15:0
7 when we started looking at it in the early 15:0
8 '90s, Houston and Austin were significantly 15:0
9 ahead of the rest of the state in having some 15:0
10 at least commercial HMOs available and being 15:0
11 used in the commercial market for employee 15:0
12 benefits. That's not to say that there 15:0
13 weren't some in the other areas, but it was 15:0
14 nowhere near a large -- you know, a large or 15:0
15 a dominant force in those areas. 15:0
16 Q. What about Dallas? 15:0
17 A. I don't remember. 15:0
18 Q. Are there studies back in the -- that you 15:0
19 have seen that talk about the commercial HMO, 15:0
20 managed care infrastructure in Texas in the 15:0
21 mid '80s, for example? 15:0
22 A. I don't know about specifically the mid 15:0
23 '80s. There has been -- as long as I've 15:0
24 been looking at it from the Medicaid 15:
25 perspective, there have been reports of the 15:

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1 penetration of HMOs by marketplace, by 15:0
2 metropolitan area and in the state as a 15:0
3 whole. 15:0
4 Q. Since -- since '91? 15:0
5 A. That I'm aware of. I can't recall earlier 15:0
6 than that that I've seen anything like that 15:0
7 prior to looking at it for Medicaid purposes, 15:0
8 which was at that time.
9 Q. Well, then, let me come back to my question. 15:0
10 How do you know that there was not a 15:0
11 infrastructure in metropolitan areas of the 15:0
12 State of Texas in 1985 if you've never seen a 15:0
13 study or report that analyzes that in the 15:0
14 State of Texas back that far? 15:0
15 A. Discussions with HMOs. 15:0
16 Q. So it's not based on reports or studies, but 15:0
17 just your discussions? 15:0
18 A. For those earlier years, yes. 15:0
19 Q. You testified that Texans are more reluctant 15:0
20 to accept the HMOs, managed care. Or 15:0
21 maybe -- maybe I didn't write it down 15:0
22 wrong -- or maybe I wrote it down wrong. 15:0
23 Are Texans more reluctant, in your view, to 15:0
24 accept HMOs and managed care? 15:0
25 A. Not Texans as a whole. 15:0

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1 Q. Okay. What about Medicaid Texans as compared 15:0
2 to Medicaid recipients in other states? Are 15:0
3 they more reluctant to accept -- 15:0
4 A. Not that I know of. 15:0
5 Q. Okay. Is there any benefit to recipients -- 15:0
6 Medicaid recipients from a long rollout 15:0
7 period; that is, extending it over a greater 15:0
8 number of years as opposed to a shorter 15:0
9 period of years? 15:0
10 A. To the extent that a rollout phased-in 15:0
11 implementation is needed in order for it to 15:0
12 be implemented correctly so that there are 15:0
13 not major mistakes and glitches made, there 15:0
14 is that benefit to minimize confusion on the 15:0
15 part of the patients. 15:0
16 Q. Oh, so you -- I see. So, for example, just 15:0
17 so we've got our terminology down right, when 15:0
18 we're talking about the rollout period, 15:0
19 you're talking about if we go into a 15:0
20 community like Austin or Houston, the amount 15:0
21 of time that it will be implemented, that is 15:0
22 whether it will be 60 days, 90 days or 120 15:0
23 days; is that correct? 15:0
24 A. No, that's not what I was referring to. 15:0
25 Q. Oh, okay. What are you referring to in terms 15:0

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1 of the implementation and rollout? 15:0
2 A. A site-by-site rollout that is not 15:0
3 instantaneously statewide, but going from 15:0
4 community to community and implementing on a 15:0
5 phased -- a phased-in basis as the state is 15:0
6 doing now. 15:0
7 Q. Okay. How does that benefit recipients? 15:0
8 A. I didn't say that it did. 15:0
9 Q. Okay. That was my original question. 15:0
10 A. Well, I'm sorry. It benefits recipients to 15:0
11 the degree that it means that the State 15:0
12 implements it correctly and efficiently and 15:0
13 there is not confusion. There are not 15:0
14 computer system breakdowns. People know 15:0
15 where they're supposed to go and understand 15:0
16 and are educated about the process. 15:0
17 Q. The problem is, then, as I think you're 15:0
18 identifying it, is if there isn't adequate 15:0
19 resources, personnel to properly administer 15:0
20 the program statewide instantaneously, then 15:0
21 it ought to be done on a rollout period. Is 15:0
22 that basically --
23 A. That's the state's decision, yes. 15:0
24 Q. Yes. If there were -- would you agree that 15:0
25 if you had adequate resources, that is, 15:0

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1 adequate trained, state personnel, that you 15:0
2 could implement this statewide without any 15:0
3 disadvantage to recipients? 15:0
4 A. I'm not sure that I can agree with that. 15:0
5 Q. Okay. Why wouldn't that work? 15:0
6 A. I think that's too big to do all at once. 15:0
7 Q. And what would be -- when you say too big, 15:0
8 what's the consequence of it being too big? 15:0
9 A. I think that's assuming an administrative 15:0
10 structure that would be extremely difficult 15:0
11 to put together, staff that would be very 15:0
12 difficult to find who were knowledgeable, and 15:0
13 just the organization of that process would 15:0
14 be extremely difficult. 15:0
15 Q. But the problems that you're identifying are 15:0
16 problems from the oversight, that is, the 15:0
17 agency oversight of the program, that is, 15:0
18 implementation of the program, whether 15:1
19 there's adequate staffing and adequate 15:1
20 experience. That's the problem you're 15:1
21 identifying, correct? 15:1
22 A. Yes. 15:1
23 Q. I mean, it's not something about the 15:1
24 recipients themselves that they have to 15:1
25 see -- they have to go see what happens in 15:1

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1 Houston. A recipient doesn't do that and 15:
2 say, "Oh, gee, I like that." 15:
3 A. No.
4 Q. "So I'm going like it here in El Paso"? 15:
5 A. Correct. 15:
6 Q. Okay. So it's an administrative issue of 15:
7 adequacy and quality of resources to properly 15:
8 roll it out and administer it, correct? 15:
9 A. Yes. 15:
10 Q. Have you ever examined what the rollout 15:
11 periods have been in other states? 15:
12 A. Yes. We've studied a number of other states. 15:
13 Q. In terms of the large states -- 10 largest 15:
14 states' Medicaid programs, what's the rollout 15:
15 period been, if you know, on average? 15:
16 A. I don't know on average. 15:
17 Q. Can you give me instances? 15:
18 A. They're done geographically by different 15:
19 administrative structures. For example, 15:
20 California has 55 separate administrative 15:
21 structures for their counties. My 15:
22 understanding that New York, who's only 15:
23 getting into this now, is -- started with New 15:
24 York City or started with upstate, I don't 15:
25 remember which it is, but one part or other 15:

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1 part of the -- of the state, and is 15:1
2 implementing in that way, but I don't know 15:1
3 what an average is. 15:1
4 Q. And you don't know -- can you tell me how 15:1
5 many years -- for example, once California 15:1
6 first decided to implement managed care, how 15:1
7 many years it took them to fully implement 15:1
8 managed care -- 15:1
9 A. No.
10 Q. -- at least on the AFDC -- 15:1
11 A. No.
12 Q. -- segment of the population? 15:1
13 A. Not how many years. 15:1
14 Q. How about for any of the other 10 largest 15:1
15 states? Do you know how many years it took 15:1
16 them to roll it out fully? 15:1
17 A. Well, not all 10 of them are rolled out 15:1
18 fully. 15:1
19 Q. Of those who have, do you know how long it 15:1
20 has taken? 15:1
21 A. No. 15:1
22 Q. Okay. You mentioned a lawsuit that had 15:1
23 prevented managed care rollout in the State 15:1
24 of Texas. 15:1
25 A. It delayed it, yes. 15:1

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1 Q. And the only question I have is, was it only 15:1
2 delayed in that one jurisdiction? 15:1
3 A. No, all of them. 15:1
4 Q. This was a suit involving Tarrant County? 15:1
5 A. And Lubbock County. 15:1
6 Q. And the injunction applied to the entire 15:1
7 state? 15:1
8 A. I don't remember if -- I don't remember the 15:1
9 legal technicalities. 15:1
10 Q. Was it your understanding that all activity 15:1
11 in terms of rolling out Medicaid in every 15:1
12 area of the state had to stop when the 15:1
13 injunction was issued? 15:1
14 A. I don't remember if that is -- if that, in 15:1
15 fact, is true or if it was part of the 15:1
16 lawsuit. I don't remember. 15:1
17 Q. Other than activities in Lubbock and Tarrant 15:1
18 County, were any other activities related to 15:1
19 managed care, that is, moving forward in 15:1
20 other counties, stalled or stayed or delayed 15:1
21 as a result of that lawsuit? 15:1
22 A. All of the counties came up a month later. 15:1
23 All counties came up a month later, but I 15:1
24 don't know --
25 Q. When you say came up a month later, what do 15:1

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1 you mean?
2 A. Were implemented a month later than they had 15:1
3 been originally planned. 15:1
4 Q. What other counties were affected, were 15:1
5 delayed this one month? 15:1
6 A. All of the sites. Well, perhaps not the 15:1
7 tri-county area, because nothing was changing 15:1
8 there. They were adding counties to that 15:1
9 site. So there are now six or seven counties 15:1
10 in that area. But everyone was supposed to 15:1
11 start on -- well, no, I may not be saying 15:1
12 that correctly. I'm afraid -- I believe that 15:1
13 San Antonio was coming up, was supposed to 15:1
14 come up in September and that everybody ended 15:1
15 up coming up on October 1, including them. 15:1
16 Q. Do you know as you sit here today whether the 15:1
17 fact that San Antonio started in October 15:1
18 instead of September was due to the suit, the 15:1
19 lawsuit? 15:1
20 A. I can't say definitively. 15:1
21 Q. And as I understand it, all we're talking 15:1
22 about here is a one-month delay? 15:1
23 A. Right. 15:1
24 Q. That's all it was delayed, right -- 15:1
25 A. Yes.

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1 Q. -- one month? Is there any other lawsuit 15:1
2 that you were referring to in any of your 15:1
3 testimony that in any way delayed 15:1
4 implementation of managed care in Texas? 15:1
5 A. No. 15:1
6 Q. Nursing homes. You testified about a 15:1
7 proposal that you had advocated for changing 15:1
8 reimbursement methodology for nursing homes, 15:1
9 and we talked about it earlier this 15:1
10 afternoon. Do you recall that? 15:1
11 A. Yes. 15:1
12 Q. Why did that measure fail? 15:
13 A. Key legislators were convinced that it was 15:
14 going to greatly inflate the cost of the 15:
15 program. 15:
16 Q. Is that what you believed caused the measure 15:1
17 to fail? 15:
18 A. Yes. 15:
19 Q. Do you believe it would have greatly 15:
20 increased the cost of the program? 15:
21 A. No. Not greatly. 15:
22 Q. You're familiar with the reimbursement 15:
23 methodology of nursing homes under Medicaid, 15:
24 Texas Medicaid? 15:
25 A. Generally. 15:

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1 Q. Do you understand what the occupancy rate 15:1
2 factor is? 15:1
3 A. Yes, generally. 15:1
4 Q. Can you explain for the record what that 15:1
5 factor is? 15:1
6 A. No, not specifically. 15:1
7 Q. Can you -- well, can you tell me generally 15:1
8 for the record what the occupancy rate factor 15:1
9 is? 15:1
10 A. It is a factor that's used in the 15:1
11 reimbursement system to keep the state from 15:1
12 paying nursing homes for a large number of 15:1
13 empty beds. 15:1
14 Q. Do you know how it works? 15:1
15 A. I no longer recall how it works. 15:1
16 Q. Do you -- do you recall a recommendation 15:1
17 being made to increase the percentage used as 15:1
18 the occupancy rate factor from 85 percent to 15:1
19 90 percent? 15:1
20 A. Of the occupancy rate factor? 15:1
21 Q. Uh-huh. 15:1
22 A. I don't remember those specific numbers, but 15:1
23 I believe there was a recommendation to 15:1
24 increase it. I just am not confident about 15:1
25 those numbers. 15:1

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1 Q. If the occupancy rate factor was increased, 15:1
2 whatever the numbers were, what would be the 15:1
3 effect of that increase? 15:1
4 A. To reduce the reimbursement rate to the 15:1
5 individual facility or to that class of 15:1
6 facilities. 15:1
7 Q. Save money for the Medicaid program? 15:
8 A. Yes. 15:
9 Q. What was the state's response to the proposal 15:
10 to increase the occupancy rate factor, if you 15:
11 know?
12 A. I don't remember. 15:
13 Q. Does it refresh your recollection that, in 15:
14 fact, the state lowered the occupancy rate 15:
15 factor? 15:
16 A. No, I do not recall that. 15:
17 Q. Do you recall the state moving to use the 15:
18 average state occupancy rate factor, as 15:
19 opposed to the set percentage occupancy rate 15:
20 factor? 15:
21 A. No. 15:
22 Q. Okay. If the occupancy rate factor is, in 15:
23 fact, reduced, I take it the effect of that 15:
24 is to increase the cost to the Medicaid 15:
25 program? 15:

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1 A. Yes. 15:1
2 Q. And to subsidize inefficient, that is, low 15:1
3 occupancy rate facilities? 15:1
4 A. Yes. 15:1
5 Q. Do you agree -- well, let me ask. Did you 15:1
6 get into the issue of nursing homes in 15:1
7 your -- as Texas Medicaid director? 15:1
8 A. Well, yes, to a certain extent. It was not 15:1
9 my primary area of work for most of my 15:1
10 tenure. 15:1
11 Q. Did you -- 15:1
12 A. But --
13 Q. Did you look at cost containment methods or 15:1
14 efforts in connection with nursing homes? 15:1
15 A. What period of time are you speaking of? I'm 15:1
16 sorry.
17 Q. During the time you were Texas Medicaid 15:1
18 director. 15:1
19 A. I'm -- I'm blanking. I'm not coming up with 15:1
20 any specific initiatives or suggestions on 15:1
21 that besides this whole methodology issue. 15:1
22 Q. Well, you mean aside from your proposal -- 15:1
23 A. Correct. 15:1
24 Q. -- to discourage -- to encourage using monies 15:1
25 paid for higher quality services. That's the 15:1

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1 proposal which you recall, right? 15:1
2 A. The facility-specific reimbursement 15:1
3 structure. 15:1
4 Q. But that, would you agree with me, is not 15:1
5 necessarily cost containment measure. 15:1
6 Indeed, there was a lot of dispute, as you 15:1
7 said, over whether it was going to save or 15:1
8 increase costs? 15:1
9 A. Right. 15:1
10 Q. So in terms of cost containment measures as 15:1
11 to the nursing home segment of Texas 15:1
12 Medicaid, can you identify any measure you 15:1
13 attempted to adopt or any initiative you 15:1
14 attempted to adopt? 15:1
15 A. No, I can't recall any. 15:1
16 Q. Do you know -- have you -- strike that. 15:1
17 Was there ever a consideration or 15:1
18 recommendation that selective contracting be 15:1
19 used in the nursing home context? 15:1
20 A. That was discussed from time to time. 15:1
21 Q. Was there ever any -- was it ever adopted? 15:1
22 A. No. 15:1
23 Q. Was it ever piloted? 15:1
24 A. I don't know. 15:1
25 Q. By that I mean, ~~was~~ it ever tried in any 15:1

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1 community to see if it worked or didn't work? 15:2
2 A. I don't know. 15:2
3 Q. Do you know whether there was any analysis 15:2
4 done of what other states' experience had 15:2
5 been with selective contracting for nursing 15:2
6 homes? 15:2
7 A. I'm not -- I don't know that there was -- 15:2
8 there had been any, but no, I don't recall 15:2
9 any study. 15:2
10 Q. Was there any effort to look to see what 15:2
11 other states had done in that regard? 15:2
12 A. I believe the Texas Performance Review did, 15:2
13 but I -- I was not involved in any of that. 15:2
14 Q. When you were Texas Medicaid director, by the 15:2
15 way, did you receive copies of the Texas 15:2
16 Performance Reviews? 15:2
17 A. Yes. 15:2
18 Q. And what efforts or what steps did you take 15:2
19 to implement the recommendations made by the 15:2
20 Texas Performance Reviews? 15:2
21 A. I implemented the recommendations that I was 15:2
22 directed to do by the legislature. 15:2
23 Q. So -- strike that. 15:2
24 Is it your testimony, 15:2
25 Ms. Friedholm, that you could not implement 15:2

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1 any of those recommendations without 15:2
2 legislative direction? 15:2
3 A. Not in a legal sense, but those were always 15:2
4 made right at the beginning of each 15:2
5 legislative session, and they were the 15:2
6 subject of extensive legislative debate, and 15:2
7 it was a very busy time and we would see what 15:2
8 the legislature said to do or not do. They 15:2
9 all received consideration. 15:2
10 Q. By the way, you said that when you were the 15:2
11 assistant to Lieutenant Governor Bullock -- 15:2
12 A. Bullock. 15:2
13 Q. I'm sorry? 15:2
14 A. Bullock. 15:2
15 Q. Yeah, didn't I say that? 15:2
16 A. I thought you said Ballock. 15:2
17 Q. Oh, I'm sorry. It's Bullock. Must be my 15:2
18 midwestern accent. I believe you testified 15:2
19 that there was -- the Texas Performance 15:2
20 Review was referred to Lieutenant Governor 15:2
21 Bullock when you were his assistant, is that 15:2
22 correct, with respect to the first? 15:2
23 A. It started under his -- he directed that it 15:2
24 begin and be done. 15:2
25 Q. And I thought you suggested that it was your 15:2

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1 job to pursue the implementation of those 15:2
2 recommendations to the extent that Lieutenant 15:2
3 Governor Bullock directed you to do that. 15:2
4 A. Well, that's not quite correct. When the 15:2
5 Performance Review report came out, the 15:2
6 lieutenant governor had each of his staff 15:2
7 people with a specific area of responsibility 15:2
8 take the lead on the legislative staff work 15:2
9 group to develop legislation to implement 15:2
10 those recommendations. 15:2
11 Q. Was there any attempt to evaluate in the 15:2
12 lieutenant governor's office those 15:2
13 recommendations to decide which ones should 15:2
14 be pursued and which ones should not be 15:2
15 pursued? 15:2
16 A. As a leader -- in a leadership role with 15:2
17 staff of other senators, that kind of process 15:2
18 took place, and then it was further done by 15:2
19 the actual legislature in the form of 15:2
20 consideration of legislation. 15:2
21 Q. I understand. But I'm getting to the heart 15:2
22 of the process before it ever gets to 15:2
23 proposed legislation. And this is my 15:2
24 question. The TPR is received -- the Texas 15:2
25 Performance Review was received by the 15:2

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1 lieutenant governor's office, correct? 15:
2 A. It's made available publicly, yes. 15:
3 Q. Okay. He gets a copy. 15:
4 A. Right.
5 Q. When he gets a copy, was there any effort 15:
6 before any legislation was drafted to decide 15:
7 which of those recommendations and proposals 15:
8 would be pursued or not pursued? 15:
9 A. I don't know that I can say it was before the 15:
10 drafting of legislation because it was all 15:
11 taking place at once on that first year. 15:
12 Q. Are you saying --
13 A. A special session was called almost 15:
14 immediately upon -- or within a couple of 15:
15 weeks of the submittal of that report with 15:
16 the idea that we would be undertaking to 15:
17 restructure state government. 15:
18 Q. Was there legislation drafted on every 15:
19 recommendation? 15:
20 A. It's my recollection that that's true. 15:
21 Q. So there wasn't any filtering process in the 15:
22 lieutenant governor's office? 15:
23 A. I don't think the first time. 15:
24 Q. Was there in subsequent years? 15:
25 A. Yes, it's my understanding that there was. 15:

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1 Q. And how did that work? 15:2
2 A. I don't know. I wasn't there. 15:2
3 Q. And what was your understanding of how it was 15:2
4 filtered? 15:2
5 A. Again, work groups formed around the 15:2
6 different issue areas, would review and 15:2
7 consult agency personnel who were 15:2
8 knowledgeable about the program, and then I 15:2
9 think by the third iteration, lieutenant 15:2
10 governor insisted that in the development of 15:2
11 the TPR recommendations, that the 15:2
12 comptroller's office actually provide an 15:2
13 opportunity for the agency staff to have some 15:2
14 input or at least review before they issued 15:2
15 their report to try to improve the accuracy 15:2
16 of some of the recommendations. 15:2
17 Q. Is it your understanding that there was no 15:2
18 agency input into the first two Texas 15:2
19 Performance Reviews? 15:2
20 A. Except for those staff -- generally speaking, 15:2
21 yes, that's true. 15:2
22 Q. You participated in the -- strike that. 15:2
23 Let me first go back to this 15:2
24 filtering process in the lieutenant 15:2
25 governor's office. When that happened, were 15:2

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1 there reports written, even internal reports, 15:2
2 with respect to the various recommendations? 15:2
3 A. I'm not in a position to know that. 15:2
4 Q. It's only your understanding that they had 15:2
5 some sort of evaluation done in the 15:2
6 lieutenant governor's office and then a 15:2
7 decision made as to which recommendations to 15:2
8 pursue? 15:2
9 A. It's my understanding that work teams 15:2
10 performed as a legislative staff to work 15:2
11 together to review and come up with some 15:2
12 recommendations, or at least for the 15:2
13 lieutenant governor's purpose, understand the 15:2
14 value of each of those, and I don't know if 15:2
15 there were written materials or not. 15:2
16 Q. I assume some reports were made in some form 15:2
17 or fashion to the lieutenant governor? 15:2
18 A. I wasn't in the office. I don't know. 15:2
19 Q. Okay. You don't know what documentation, 15:2
20 then, was generated in these work groups? 15:2
21 A. No, I do not. 15:2
22 Q. What was your involvement in the first Texas 15:2
23 Performance Review, Breaking the Mold? 15:2
24 A. A couple of times staff people -- that 15:2
25 particular Performance Review, which was the 15:2

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1 first, was done by borrowing staff from 15:2
2 various and sundry places across state 15:2
3 government, including the Legislative Budget 15:2
4 Board, the Sunset Board, and random other 15:2
5 people that came from different positions. 15:2
6 They didn't necessarily always work in the 15:2
7 area that they came from. In other words, a 15:2
8 person from MHMR might not necessarily work 15:2
9 on anything to do with MHMR, but they could 15:2
10 work in the general human services area. All 15:2
11 of that was kept secret, so you didn't know 15:2
12 who was working on what. 15:2
13 But I was interviewed as a staff 15:2
14 member to Lieutenant Governor Bullock, and 15:2
15 basically those conversations -- I think 15:2
16 there were two -- were around the issue of if 15:2
17 we were to restructure health and human 15:2
18 services, what should it look like. And then 15:2
19 upon the publication of that document, I 15:2
20 staffed the lieutenant governor on that in 15:2
21 terms of working with interested senators and 15:2
22 having legislation that implemented their 15:2
23 version or some variation of that version 15:2
24 passed through the legislature. And we did 15:2
25 briefings on the proposals for restructuring 15:2

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1 health and human services. 15:2
2 Q. And when you say "restructuring health and 15:2
3 human services," you're referring to that 15:2
4 portion of Breaking the Mold that referred to 15:2
5 trying to eliminate the large number of 15:2
6 different agencies involved in the delivery 15:2
7 of health and human services to increase the 15:2
8 coordination, to increase the planning -- 15:2
9 A. Yes. 15:2
10 Q. -- decrease the duplication and inefficiency, 15:2
11 those portions? 15:2
12 A. Correct. 15:2
13 Q. Did you write that portion? 15:2
14 A. No. As I have already said, I received that 15:2
15 report. 15:2
16 Q. Oh, I thought you said that -- I'm sorry. I 15:2
17 did misunderstand. I thought that you had 15:2
18 actually participated in that section of 15:2
19 Breaking the Mold? 15:2
20 A. No. I was interviewed for my thoughts about 15:2
21 it, and then they went back and wrote it and 15:2
22 published it. 15:2
23 Q. And then you participated -- participated 15:2
24 as -- in your function with the lieutenant 15:2
25 governor's office -- in attempting to have it 15:2

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1 implemented. Is that what you're saying? 15:2
2 A. In having it go through the legislative 15:2
3 process. 15:2
4 Q. So you -- did you advocate the implementation 15:2
5 of those recommendations of that portion of 15:2
6 Breaking the Mold? 15:2
7 A. We ended up coming up with a slightly 15:2
8 different version of that recommendation, of 15:2
9 consolidating some of the small agencies into 15:2
10 large agencies, but not into one single 15:2
11 agency and the development of a commission to 15:
12 oversee. 15:
13 Q. Okay. That was the initial proposal or the 15:
14 end of the legislation? Are you referring to 15:
15 the proposal advocated or the final 15:
16 legislation adopted? 15:
17 A. There were so many different versions of this 15:
18 proposal in a very short period of time that 15:
19 I do not remember if the exact proposal that 15:
20 the comptroller's office made in Breaking the 15:
21 Mold was introduced specifically as 15:
22 legislation. I do recall that there were a 15:
23 number of Senate and House members who were 15:
24 key people who had concerns about it and 15:
25 wanted to pursue a variation on that theme, 15:

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1 and -- and I worked to try to come up with a 15:3
2 proposal that would pass muster with the 15:3
3 Senate and then ultimately hopefully with the 15:3
4 House. 15:3
5 Q. Okay. Let me back up for a second on 15:3
6 Breaking the Mold, Ms. Friedholm. You 15:3
7 testified in response to John Hay's 15:3
8 examination, and I remember this, that you 15:3
9 felt very strongly about the competency and 15:3
10 dedication of state employees. 15:3
11 A. Of the Medicaid state employees. 15:3
12 Q. Medicaid state employees. Is it your view 15:3
13 that that's different for other kinds of 15:3
14 state employees? 15:3
15 A. I can't speak very knowledgeably about other 15:3
16 parts of state government. 15:3
17 Q. Would you agree that with respect to the 15:3
18 preparation of the Texas Performance Reviews, 15:3
19 that there are equally qualified and 15:3
20 dedicated people who have been involved in 15:3
21 the preparation of those reports? 15:3
22 A. I think they're equally dedicated. I don't 15:3
23 know that they're equally qualified. 15:3
24 Q. Are you suggesting that there were 15:3
25 unqualified people who were involved in the 15:3

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1		performance of the Texas Performance	15:3
2		Reviews -- involved in the preparation,	15:3
3		excuse me, of the Texas Performance Reviews?	15:3
4	A.	I'm suggesting there are people who didn't	15:3
5		know much about Medicaid who sometimes	15:3
6		prepared those recommendations. They also	15:3
7		contracted out many of those to private	15:3
8		groups that were not very knowledgeable of	15:3
9		the Medicaid program in Texas and they were	15:3
10		prohibited from having discussions with state	15:3
11		people who knew anything about Medicaid in	15:3
12		Texas --	15:3
13	Q.	I take it you're --	
14	A.	-- and as a result there are erroneous things	15:3
15		in those Performance Reviews.	15:3
16	Q.	I take it you're critical of the	15:3
17		comptroller's office for the way in which	15:3
18		those Texas Performance Reviews were	15:3
19		prepared?	15:3
20	A.	In some cases.	15:3
21	Q.	Are we talking about specific Texas	15:3
22		Performance Reviews or all of them?	15:3
23	A.	Just specific ones.	15:3
24	Q.	Which ones?	15:3
25	A.	I can't remember the names of them.	15:3

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1 Q. Can you tell me --
2 A. We'd have to go through all of them. 15:3
3 Q. Well, let me give you the names of them and 15:3
4 then tell me whether you think that the 15:3
5 comptroller's office did or didn't do a good 15:3
6 job in the preparation of the report. 15:3
7 Breaking the Mold. 15:3
8 A. I don't remember the Medicaid-specific 15:3
9 recommendations on Breaking the Mold. 15:3
10 Sorry. The restructuring one was the big one 15:
11 from that that I was involved with, and I 15:
12 think that they did a good job. 15:
13 Q. That -- 15:
14 A. That's not Medicaid, though. 15:
15 Q. I understand. And we're talking about the -- 15:
16 which portion -- 15:
17 MR. FENNELL: Let's go off the 15:
18 record. 15:
19 THE VIDEOGRAPHER: Stand by, 15:
20 please. The time is 3:34 p.m. We're off the 15:
21 record. 15:
22 (RECESS) 15:
23 THE VIDEOGRAPHER: Stand by, 15:
24 please. The time is 3:38 p.m. We're on the 15:
25 record. 15:

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1 Q. Ms. Friedholm, I don't have a copy of the 15:3
2 report that I'm able to mark. I do have a 15:3
3 copy, or my copy of the table of contents of 15:3
4 Breaking the Mold, and if I could, let me 15:3
5 show you that, and ask you if you could 15:3
6 indicate for the record which portions of the 15:3
7 report, Breaking the Mold, you were 15:3
8 interviewed with respect to, if you know. 15:3
9 A. None of these ring a bell to me. This is the 15:3
10 first -- 1991? 15:3
11 Q. Yes. July 1991. 15:3
12 A. These names are not helpful to me. 15:3
13 Q. Can you describe for the record more clearly 15:3
14 those portions of the report that you were 15:3
15 interviewed with respect to? 15:3
16 A. The restructuring of health and human 15:3
17 services agencies. 15:3
18 Q. And this is the portion of the report that 15:3
19 was critical of the fact that Texas had 14 15:3
20 different agencies involved in health and 15:3
21 human services? 15:3
22 A. Yes. 15:3
23 Q. And that recommended that it should be 15:4
24 consolidated into a single agency? 15:4
25 A. That was their recommendation, yes. 15:4

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1 Q. And you did not agree with that 15:4
2 recommendation, or did agree? 15:4
3 A. There are pluses and minuses either way you 15:4
4 go. My concern was that we consolidate as 15:4
5 many as we could. I did not know if one was 15:4
6 the proper answer because of the size, the 15:4
7 magnitude of health and human services. 15:4
8 Q. My understanding is that in the ultimate 15:4
9 legislation, the number of agencies was not 15:4
10 reduced from 14 to some smaller number, but, 15:4
11 in fact, there was an additional agency 15:4
12 created; is that correct? 15:4
13 A. Well, there was -- there were changes in the 15:4
14 agencies. There was definitely the creation 15:4
15 of the commission. 15:4
16 Q. Was there any reduction in the number of 15:4
17 agencies? 15:4
18 A. For some reason, I'm thinking there were 11 15:4
19 when it was all said and done. But I'd have 15:4
20 to sit and try to go through those. 15:4
21 Q. Without going into specific numbers, let me 15:4
22 just ask, was there a reduction in the number 15:4
23 of agencies from that which existed before 15:4
24 Breaking the Mold to that which existed after 15:4
25 the legislation implemented? 15:4

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1 A. No, I don't think so. 15:4
2 Q. Okay. Medicaid is a portion of health and 15:4
3 human services, correct? 15:4
4 A. Yes. 15:4
5 Q. And it was being administered, portions of 15:4
6 it, by how many different agencies? 15:4
7 A. One. 15:4
8 Q. Which agency? 15:4
9 A. Department of Human Services. 15:4
10 Q. Do you agree with the conclusion of this 15:4
11 report that there needed to be an overall 15:4
12 plan for health and human services? 15:4
13 A. Yes. 15:4
14 Q. Did you agree with the criticism or 15:4
15 recommendations both of the report that there 15:4
16 was a lack of coordination among these 15:4
17 agencies? 15:4
18 A. Yes, to some extent. 15:4
19 Q. It got into specifics about lack of sharing 15:4
20 data and lack of having a single eligibility 15:4
21 determination system. Do you remember those 15:4
22 recommendations and criticisms? 15:4
23 A. Only vaguely. 15:4
24 Q. Did you agree with them at the time? 15:4
25 A. I agreed that there needed to be improvements 15:4

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1 in data systems and automation systems and 15:4
2 appropriate sharing. I also am -- was and am 15:4
3 a proponent of a improved computerized 15:4
4 eligibility system, updated from the current 15:4
5 state system. 15:4
6 Q. Were you a proponent or did you agree with 15:4
7 the recommendation that there ought to be an 15:4
8 integrated eligibility system, that is, a 15:4
9 single eligibility system for all of the 15:4
10 health and human services agencies? 15:4
11 A. I can't say a single one for all, but that 15:4
12 there are -- I remember we looked at it and 15:4
13 there are four or five programs which 15:4
14 constitute the vast majority of numbers of 15:4
15 people and dollars, and at least those. 15:4
16 Q. Have those four or five ever been integrated? 15:4
17 A. They're working on it. 15:4
18 Q. Has not yet been implemented? 15:4
19 A. No, it has not. 15:4
20 Q. Would you agree that lack -- strike that. 15:4
21 Do you agree that there was a 15:4
22 problem of a lack of an overall plan in the 15:4
23 State of Texas to address health and human 15:4
24 services? 15:4
25 A. I think it's important to have plans. There 15:4

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1 was not one overall plan. There were plans 15:4
2 developed by individual major programs 15:4
3 usually as a result of federal requirements. 15:4
4 Q. Do you agree that there should have been and 15:4
5 should be an overall integrated plan of all 15:4
6 these health and human service agencies and 15:4
7 the services they provide? 15:4
8 A. I am less a proponent of that today than I 15:4
9 used to be. 15:4
10 Q. You were at one time at least. 15:4
11 A. Yes. 15:4
12 Q. Were you at the time you were Medicaid 15:4
13 director? 15:4
14 A. I don't remember being involved in it while I 15:4
15 was a Medicaid director. 15:4
16 Q. With respect to the recommendations and 15:4
17 criticisms in Breaking the Mold as it applied 15:4
18 to Medicaid, did you review those at the time 15:4
19 this report was issued? 15:4
20 A. Yes, but I, for the life of me, cannot 15:4
21 remember anything except the restructuring 15:4
22 recommendation from that unless that was also 15:4
23 the managed care year. 15:4
24 Q. Have you -- have you in connection with your 15:4
25 opinions in this case reviewed any of the 15:4

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1 Texas Performance Reviews? 15:
2 A. I did not review that one. I reviewed the 15:
3 other ones. 15:
4 Q. You did not review the first one, Breaking 15:
5 the Mold?
6 A. Right, I didn't have that one. 15:
7 Q. You reviewed the subsequent three? 15:
8 A. Yes. 15:
9 Q. In connection with your opinions in this 15:
10 case? 15:
11 A. In preparation for the deposition. 15:
12 Q. Okay. 15:
13 MR. FENNELL: Can I ask on the 15:
14 record why those weren't produced as part of 15:
15 the reviewed documents? 15:
16 MR. HART: You asking me? 15:
17 MR. FENNELL: Yes. 15:
18 MR. HART: If they are not in 15:
19 there, we'll get them to you. She's not 15:
20 relying on them, so I mean --
21 Q. Did Counsel -- was Counsel aware you reviewed 15:
22 those documents in connection with your
23 opinions?
24 A. I don't think he and I discussed it.
25 Q. Did Counsel ask you for all documents that

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1 you had reviewed in connection with your 15:4
2 opinions in this case? 15:4
3 A. In connection with my opinions? 15:4
4 Q. Yes.
5 A. Yes. 15:4
6 Q. And you gave him what has been marked as 15:4
7 Exhibit 2? 15:4
8 A. Yes. 15:4
9 Q. You did not give him the Texas Performance 15:4
10 Reviews? 15:4
11 A. I don't think they have anything to do with 15:4
12 my opinions. 15:4
13 Q. But I thought you said you reviewed them in 15:4
14 connection with your opinions. 15:4
15 A. No, you said that. I said I reviewed them in 15:4
16 connection with this deposition. I'm both a 15:4
17 fact and an opinion witness. 15:4
18 Q. So you have reviewed them in connection with 15:4
19 your fact testimony in this case, but not 15:4
20 your opinions in this case as an expert; is 15:4
21 that correct?
22 A. I do not believe they had any influence on my 15:4
23 opinions. 15:4
24 Q. Okay. I'm not asking you whether they had 15:4
25 any influence on your opinions. I'm just 15:4

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1 asking whether you reviewed them in 15:4
2 connection with your testimony in this case. 15:4
3 Don't limit it to expert testimony, but 15:4
4 testimony that you anticipate providing. 15:4
5 A. I don't plan to offer testimony that has to 15:4
6 do with those reviews. 15:4
7 Q. Let me state it again. I understand you may 15:4
8 not -- you're not planning on offering any 15:4
9 testimony about the Texas Performance 15:4
10 Reviews? 15:4
11 A. I don't have affirmative plan to do that, 15:4
12 no. 15:4
13 Q. Have you been asked to do that?
14 MR. HART: Let me say something on 15:4
15 the record. 15:4
16 MR. FENNELL: Only, Jim--
17 MR. HART: I think what she's 15:4
18 telling you is she's reviewed the documents. 15:4
19 They're not something she's relying upon, and 15:4
20 we'll give the documents to you. So I think 15:4
21 that solves the problem. 15:4
22 Q. I've got to have the record clear on this, 15:4
23 Ms. Friedholm. You have not been asked to 15:4
24 give any opinions about the Texas Performance 15:4
25 Reviews, correct? 15:4

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1 A. No. 15:4
2 Q. You have not been asked to give any testimony 15:4
3 concerning the Texas Performance Reviews, 15:4
4 opinion or fact testimony; is that correct? 15:4
5 MR. HART: Well, we're not -- 15:4
6 she's -- what she's to do with fact 15:4
7 testimony is not -- 15:4
8 MR. FENNELL: Jim, this is improper 15:4
9 for you to be -- 15:4
10 MR. HART: No, it's not.
11 MR. FENNELL: -- instructing this 15:4
12 witness on any matter other than privilege, 15:4
13 and you know that. 15:4
14 MR. HART: I'm trying to just tell 15:4
15 you what our obligation was, to give to you 15:4
16 documents that she's reviewed -- either she's 15:4
17 relying on or she's reviewed. And 15:4
18 inadvertently, the Performance Reviews have 15:4
19 not been produced and we'll give them to 15:4
20 you. 15:4
21 MR. FENNELL: Jim, I'd ask you not 15:4
22 to make those kinds of statements on the 15:4
23 record in the future, and I think it's 15:4
24 improper. I do. 15:4
25 Q. And, Ms. Friedholm, let me ask it again. 15:4

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1 Have you been asked to give any testimony 15:4
2 with respect to the Texas Performance Reviews 15:4
3 of any kind -- any testimony of any kind, 15:4
4 whether you want to characterize it as 15:4
5 opinion or fact testimony, have you been 15:4
6 asked to give any at the time of trial with 15:4
7 respect to the Texas Performance Reviews? 15:4
8 A. No, I have not. 15:4
9 Q. And you were not asked to review them in 15:
10 connection with your testimony in this case; 15:
11 is that correct?
12 A. I don't know how you're using the terms 15:
13 "testimony." You're confusing me. 15:
14 Q. Were you asked by counsel for the plaintiff 15:
15 to review the Texas Performance Review for 15:
16 any purpose, any of the Texas Performance 15:
17 Reviews? 15:
18 A. I don't believe I was asked by them. I am 15:
19 aware that they are criticisms of the program 15:
20 and I wanted to review some of them in case 15:
21 you asked me questions about it. 15:
22 Q. My question, though, is whether counsel for 15:
23 the plaintiff asked you to review the Texas 15:
24 Performance Reviews. 15:
25 A. No. 15:

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1 Q. For any purpose? 15:5
2 A. Not that I recall. 15:5
3 Q. Now, you have reviewed them for some 15:5
4 purpose. We're going to get to that, 15:5
5 correct? 15:5
6 A. I reviewed a few of them, yes. 15:5
7 Q. And you reviewed them in connection with the 15:5
8 deposition -- anticipated deposition 15:5
9 testimony in this case, correct? 15:5
10 A. I used them to prepare for this deposition, 15:5
11 yes. 15:5
12 Q. And is it your testimony that you did not let 15:5
13 your counsel know, did not tell your counsel 15:5
14 that you had reviewed those documents? 15:5
15 A. I don't think that it came up. It's not 15:5
16 primary in my testimony. 15:5
17 Q. The question again. Did you tell your 15:5
18 counsel that you reviewed those documents? 15:5
19 A. I do not believe I told them. 15:5
20 Q. Now, with respect to the later Texas 15:5
21 Performance Reviews, you reviewed Against the 15:5
22 Grain. 15:5
23 A. I'm sorry. You refer to these by names that 15:5
24 I can no longer keep straight. 15:5
25 Q. The second Texas Performance Review was 15:5

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1 called Against the Grain. Do you recall 15:5
2 that? 15:5
3 A. If you say so. 15:5
4 Q. Did you review the second Performance -- 15:5
5 Texas Performance Review? 15:5
6 A. I would have to look at it to see if I 15:5
7 actually read anything in it. I looked at 15:5
8 the table of contents. I don't recall which 15:5
9 ones are in that one as opposed to the later 15:5
10 ones, and I would have to look at it to be 15:5
11 able to tell you which ones I specifically 15:5
12 read. I didn't read every single one. 15:5
13 Q. On the record -- let me just state for the 15:5
14 record, this is the problem in not having 15:5
15 produced the documents that you reviewed. We 15:5
16 don't have the documents you reviewed here, 15:5
17 correct? 15:5
18 A. No, I failed to bring them. 15:5
19 Q. Did you have any -- let me ask it to you in a 15:5
20 broader fashion since we don't have those 15:5
21 here. Did you have any criticisms of the 15:5
22 conclusions in any of the three subsequent 15:5
23 Texas Performance Reviews? 15:5
24 A. Yes, I did. 15:5
25 Q. And can you tell us which ones you had 15:5

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1 criticism of? And then we'll ask about the 15:5
2 specifics as to each. 15:5
3 A. This is really off the top of my head. I 15:5
4 don't know how to reference these documents 15:5
5 except to give a bit of a description. One 15:5
6 was the comptroller's estimates of savings 15:5
7 for selective contracting which we were 15:5
8 already in the process of doing when they did 15:5
9 their report. One was their recommendations 15:5
10 on disproportionate share in one of those 15:5
11 years. It was one of the first 15:5
12 recommendations of that year. There were 15:5
13 factual things that were incorrect in that, 15:5
14 could not be implemented as they had 15:5
15 proposed, and again, we were already in the 15:5
16 process of doing it when they filed their 15:5
17 report. There was another one of that same 15:5
18 year, I believe, 1995, where there was a -- 15:5
19 there were three recommendations in one 15:5
20 numbered, like HHS 3 or so, that had to do 15:5
21 with sole community hospitals. There were 15:5
22 three hospital-related reimbursement 15:5
23 methodologies -- recommendations, not 15:5
24 methodologies. Recommendations. And upon 15:5
25 analysis and review of it, none of them were 15:5

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1 appropriate for Texas, given what we were 15:5
2 already doing, and we had to spend a lot of 15:5
3 time educating people and debating with the 15:5
4 TPR people who had not done the 15:5
5 recommendation. They had contracted out to 15:5
6 an out-of-state group, and it ended up that 15:5
7 none of those were implemented. Those are 15:5
8 the ones that immediately come to mind. 15:5
9 Q. Okay.
10 A. And again, I apologize for failing to bring 15:5
11 those. 15:5
12 Q. Do you recall any other portions of those 15:5
13 three Texas Performance Reviews that you 15:5
14 disagreed with or that -- let me rephrase 15:5
15 that. Was there any other portion of those 15:5
16 three Texas Performance Reviews, 15:5
17 Ms. Friedholm, that upon reading them in 15:5
18 preparation for this deposition that you 15:5
19 disagreed with? 15:5
20 A. Those are the only ones that I can recall 15:5
21 right now. 15:5
22 Q. With respect to the first Texas Performance 15:5
23 Review, you did not review it in connection 15:5
24 with your preparation for your deposition 15:5
25 testimony, correct? 15:5

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1 A. Correct. 15:5
2 Q. You have testified here with respect to the 15:5
3 sections that relate to consolidation of 15:5
4 agencies. 15:5
5 A. Yes. 15:5
6 Q. Do you recall if you had any criticism of the 15:5
7 first Texas Performance Review -- any other 15:5
8 portion of the Texas Performance Review -- 15:5
9 first Texas Performance Review called 15:5
10 Breaking the Mold?
11 A. I only recall two of those provisions, 15:5
12 period, and I don't know that there were more 15:5
13 than two, quite frankly, because all of the 15:5
14 energy, all of the consideration and debate 15:5
15 and work were around the restructuring of the 15:5
16 agencies for which we had a special session 15:5
17 and in which we also put the recommendation 15:5
18 to do managed care pilots, and those are the 15:5
19 two recommendations from that that I recall. 15:5
20 Q. And did you disagree with the recommendations 15:5
21 in either of those two areas? 15:5
22 A. Only to the extent that I've already 15:5
23 expressed about the restructuring, that I 15:5
24 wasn't sure that we needed to have or should 15:5
25 have one agency for all health and human. 15:5

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1 But agreed in large part with all the rest of 15:5
2 it. 15:5
3 Q. All the rest of it? 15:5
4 A. Of that one. 15:5
5 Q. All the rest of the recommendations in that 15:5
6 area of the report? 15:5
7 A. Well, the discussion of the need for improved 15:5
8 data sharing, improved eligibility systems, 15:5
9 better coordination between agencies, all of 15:5
10 those issues, yes. 15:5
11 Q. Did you agree with the conclusions that there 15:5
12 was significant inefficiency and waste by 15:5
13 reason of the fragmentation of the agencies 15:5
14 and the structure? 15:5
15 A. What's significant? Is that what it said? I 15:5
16 don't recall what it said. 15:5
17 Q. Whatever its terminology, whether it said 15:5
18 significant or substantial, did you agree 15:5
19 with its conclusions with respect to the 15:5
20 extent of inefficiency and waste in -- as a 15:5
21 result of the fragmentation of those 15:5
22 agencies? 15:5
23 A. I don't recall what extent it listed, so I 15:5
24 can't say right here. 15:5
25 Q. Do you agree that there is and has been 15:5

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1 inefficiency and waste -- we can talk about 15:5
2 quantification later -- in the Texas delivery 15:5
3 of health and human services by reason of the 15:5
4 fragmented structure, lack of coordination, 15:5
5 lack of sharing of information, lack of 15:5
6 overall planning? 15:5
7 A. I think that there has been inefficiencies. 15:5
8 I don't know if I can use the term "waste." 15:5
9 I know it has made it much more difficult for 15:5
10 clients to get services. 15:5
11 Q. That is, it's impeded access? 15:5
12 A. Yes. 15:5
13 Q. And impeding access has a consequence both to 15:5
14 the individual and to the system in terms of 15:5
15 increased later health care costs, correct? 15:5
16 A. Oh, you're talking about health care now? 15:5
17 Q. Talking about any portion, but health care is 15:5
18 a portion, correct? 15:5
19 A. Health care is a portion. 15:5
20 Q. If there's a problem of access in terms of 15:5
21 receiving health care, you would agree that 15:5
22 that results in increased costs later for the 15:5
23 program? 15:5
24 A. Not necessarily for the program. For the 15:5
25 individual, and ~~to~~ the extent that the 15:5

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1 individual is still eligible for the program, 15:5
2 then for the program. Otherwise, it saves 15:5
3 money. 15:5
4 Q. Doesn't necessarily save money for the state, 15:5
5 depending on who's picking up the cost? 15:5
6 A. Well, for -- technically for the state, it 15:5
7 probably does save money. For the people, 15:5
8 the taxpayers of the State of Texas it may 15:5
9 not save money. I'm sorry. I don't mean to 15:5
10 play games, but there are real distinctions 15:
11 there. And it has played against doing 15:
12 anything to spend more money. 15:
13 Q. I'm sorry? 15:
14 A. And it plays against doing anything to spend 15:
15 more money. 15:
16 Q. Is it -- are you suggesting by that that 15:
17 impeding access is a desirable goal of the 15:
18 state because then they can reduce their 15:
19 costs by not having to provide services for 15:
20 those people? 15:
21 A. I would never argue that, but there are those 15:
22 who do. 15:
23 Q. Has it been the state policy to do that? 15:
24 A. Not as an official policy. 15:
25 Q. Has it been an unofficial policy of the state 15:

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1 to do that? 15:5
2 A. I think neglective problems has been the 15:5
3 unofficial policy of the State. 15:5
4 Q. And has neglective problems as an unofficial 15:5
5 policy of the State resulted in higher costs 15:5
6 to the state, in your opinion? 15:5
7 A. It would have -- totally depend on what time 15:5
8 frame that you're referring to. 15:5
9 Q. Well, I'll talk about any time frame, at any 15:5
10 time. 15:5
11 A. You know, in my personal opinion, I believe 16:
12 so. 16:
13 Q. Can you tell me what years? 16:
14 A. No. 16:
15 Q. Has it been -- well, what -- can you give me 16:
16 a period of time in which that was the case? 16:
17 A. No. 16:
18 Q. You know it exists, but you can't tell me 16:
19 when? 16:
20 A. For example, I think the state's reluctance 16:
21 to spend money on poor families to educate 16:
22 and job train the heads of households has led 16:
23 to generations of people living in poverty 16:
24 and not meeting their full abilities to take 16:
25 care of themselves. 16:

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1 Q. Which in turn causes those people living in 16:0
2 poverty to incur -- to experience less 16:0
3 healthy life-styles and incur higher health 16:0
4 care costs, correct? 16:0
5 A. Yes, although usually they cycle off the 16:0
6 Medicaid programs so the state doesn't pay 16:0
7 that cost. 16:0
8 Q. And may factor into charity care, correct? 16:0
9 A. Yes, they could. 16:0
10 Q. And charity care expenses -- costs therefore 16:0
11 go up? 16:0
12 A. Yes. 16:0
13 Q. I think we got off on this tangent when we 16:0
14 were talking about the two portions of the 16:0
15 first Texas Performance Review that you could 16:0
16 recall. One was the agency structure portion 16:0
17 and the other was the managed care portion. 16:0
18 A. Uh-huh. 16:0
19 Q. Were you --
20 A. I believe you have it there. I'd be happy to 16:0
21 look through it and find the health and human 16:0
22 services section. 16:0
23 Q. Unfortunately, this is my copy, 16:0
24 Ms. Friedholm. I've got notes and marks -- 16:0
25 A. Oh, okay.

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1 Q. -- and highlights and everything all over 16:0
2 it.
3 A. I see. I misunderstood. I thought you said 16:0
4 you couldn't mark on it, so I misunderstood. 16:0
5 Q. I can't -- I mean, I can't give you a marked 16:0
6 copy -- 16:0
7 A. A marked copy, right. 16:0
8 Q. -- because I release it, therefore.
9 A. Okay. I misunderstood you. 16:0
10 Q. If I had a clean copy, believe me, I would -- 16:0
11 I would provide it to you. And Mr. Hay is 16:0
12 looking again to see if we have one. I -- we 16:0
13 looked a minute ago. 16:0
14 As to the managed care portion of 16:0
15 that report, did you have any criticism of 16:0
16 the conclusions or recommendations in that 16:0
17 portion of the report? 16:0
18 A. No. 16:0
19 Q. By the way, I forgot to ask you. I was asked 16:0
20 to ask you that with respect to that 16:0
21 Department of Health program that was 16:0
22 implemented in the last two years with 16:0
23 respect to smoking, do you remember that? 16:0
24 A. Yes. 16:0
25 Q. Do you remember the name of the program? 16:0

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A. I don't remember the name of it. I remember seeing just the billboards and posters. I don't know if it has a name per se.

Q. Your criticisms of the three subsequent Texas Performance Reviews, the first one you mentioned was the comptroller's estimate of savings from selective contracting. Do you remember that?

A. I'm not sure that I can speak to this last round. I don't think I saw any of this last, so really it's the two subsequent. It's the -- it's '93 and '95. I had nothing to do with '97.

Q. Okay. So the two middle reports?

A. Yes.

Q. Okay. And you had identified three areas that you were critical of their conclusions or recommendations. Remember we just talked about that a few minutes ago?

A. Yes.

Q. And the first one you mentioned was the comptroller's estimate of the savings from selective contracting.

A. Yes.

Q. And you said that Medicaid already had this

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1 in process, which is selective contracting? 16:0
2 A. Yes, we were already in the process of -- 16:0
3 Q. Pursuing it? 16:0
4 A. -- pursuing selective contracting. 16:0
5 Q. On a more aggressive scale, or pursuing it at 16:0
6 all, I guess? 16:0
7 A. It was part of our settlement with the 16:0
8 nursing -- I mean, excuse me, the hospitals 16:0
9 in the Texas Hospital Association lawsuit was 16:0
10 that we would -- subsequent to the 16:0
11 settlement, the state would be pursuing 16:0
12 selective contracting and that was prior to 16:0
13 the Texas Performance Review coming out, so 16:0
14 we were in the process of contracting with an 16:0
15 outside group to help us implement selective 16:0
16 contracting on a statewide basis. 16:0
17 Q. So your point is that the need to pursue 16:0
18 selective contracting was kind of old news by 16:0
19 the time the Texas Performance Review made 16:0
20 that recommendation. Is that your point? 16:0
21 A. Let me put it this way. We were in the 16:0
22 process and would have implemented whether 16:0
23 TPR existed or not. 16:0
24 Q. Okay. Is there any reason why Texas could 16:0
25 not have implemented selective contracting 16:0

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1		five years earlier?	16:0
2	A.	Not that I know of.	16:0
3	Q.	How about 10 years earlier?	16:0
4	A.	Not that I know of.	16:0
5	Q.	Is there anything -- other than the fact that	16:0
6		the comptroller included this recommendation	16:0
7		in his report and you were already doing it,	16:0
8		were you in any other way -- did you in any	16:0
9		other way disagree with his conclusions or	16:0
10		recommendations?	16:0
11	A.	Well, as I stated, I was concerned about the	16:0
12		level of savings they assumed that we could	16:0
13		find.	16:0
14	Q.	So you thought -- it was your belief that he	16:0
15		had overestimated the savings from selective	16:0
16		contracting?	16:0
17	A.	Yes. For the biennium, for the first	16:0
18		biennium.	16:0
19	Q.	What about overall or for -- I think he had	16:0
20		both a first biennium and then a five-year or	16:0
21		another estimate of savings. Do you recall	16:0
22		what it was?	16:0
23	A.	My concern was with that first biennium, and	16:0
24		no, I don't recall what those later ones	16:0
25		were.	16:0

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1 Q. Has selective contracting in the experience 16:0
2 of the Medicaid -- Texas Medicaid been a cost 16:0
3 savings? 16:0
4 A. Yes, it has. 16:0
5 Q. And how substantial has the cost savings 16:0
6 been? 16:0
7 A. I cannot speak for any of the years after I 16:0
8 left the state, but that first go-round, I 16:0
9 think it was between 80 and 100 million 16:0
10 dollars, total savings. 16:0
11 Q. For what period of time? 16:0
12 A. For a -- like a 14- or 16-month period of a 16:0
13 24-month biennium. 16:0
14 Q. And how much of that would have been related 16:0
15 or was related to Medicaid? 16:0
16 A. It's all Medicaid. Selective contracting? 16:0
17 Q. Yeah, but that report -- okay. 16:0
18 A. I'm sorry. 16:0
19 Q. The report had talked about selective 16:0
20 contracting in a lot of different areas. 16:0
21 A. Oh, it did? 16:0
22 Q. And you're only focusing on the Medicaid 16:0
23 portion; is that correct? 16:0
24 A. I am only focusing on Medicaid. I cannot 16:0
25 speak to any other part -- 16:0

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1 Q. Okay.
2 A. -- of the Performance Review, except that 16:0
3 relevant to Medicaid and then that other 16:0
4 restructuring piece that we've already 16:0
5 discussed. 16:0
6 Q. And the cost savings, just so the record is 16:0
7 clear, was achieved in the first, did you say 16:0
8 60 months? 16:0
9 A. I believe it was around 16 months. It was 16:0
10 not quite a full biennium.
11 Q. 16 months -- excuse me -- was in the Medicaid 16:0
12 80 to $100 million? 16:0
13 A. That's my recollection. 16:0
14 Q. Was there any effort made by the state or by 16:0
15 you or by people under you to go back and 16:0
16 estimate what the lost monies were, that is, 16:0
17 how much money was lost because selective 16:0
18 contracting had not been pursued five years 16:0
19 or 10 years earlier? 16:0
20 A. No. 16:0
21 Q. I'm going to defer to Mr. Hay the Dispro 16:0
22 portion of this issue and he'll address 16:0
23 that. 16:0
24 In terms of -- Ms. Friedholm, in 16:0
25 terms of the Medicaid program overall, 16:0

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1 looking at it globally, it is my 16:0
2 understanding that the federal government has 16:0
3 certain mandatory requirements, that is, the 16:0
4 state must meet certain requirements. 16:0
5 A. Yes. 16:0
6 Q. That's assuming that the state chooses to 16:0
7 participate. 16:0
8 A. At all, yes. 16:0
9 Q. You agree the state has a choice whether to 16:0
10 participate in Medicaid or not, correct? 16:0
11 A. Legally, theoretically, yes. 16:0
12 Q. Yes. Well, some states didn't participate or 16:0
13 choose to participate in the Medicaid program 16:0
14 until later years. Not all adopted and chose 16:0
15 to participate in Medicaid in the 1960s 16:0
16 certainly, correct? 16:0
17 A. The only one I know of is Arizona. 16:0
18 Q. Arizona is a good example. It didn't 16:0
19 implement Medicaid or choose to participate 16:0
20 in that program until 1981, correct? 16:0
21 A. Correct. Did you find it? 16:0
22 MR. FENNELL: Somebody got it. 16:0
23 Just for the record -- just for the record, 16:0
24 let me have this marked as Deposition 16:0
25 Exhibit -- Friedholm Deposition Exhibit No. 16:0

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1 11. 16:0
2 THE VIDEOGRAPHER: I need to change 16:0
3 videotape. 16:0
4 MR. FENNELL: Okay. Yeah, all she
5 has to do is put a sticker on it.
6 THE WITNESS: In about five
7 minutes?
8 THE VIDEOGRAPHER: Yeah, within the
9 next five minutes.
10 THE WITNESS: I thought you meant
11 you were changing it right now. I apologize.
12 (Deposition Exhibit No. 11 16:
13 (marked for identification
14 Q. Ms. Friedholm, just for the record, we have 16:
15 come up with a copy of the -- or a portion of 16:
16 the first Texas Performance Review entitled 16:
17 Breaking the Mold, and that is identified as 16:
18 Exhibit 11; is that correct? 16:
19 A. Yes. 16:
20 Q. Maybe Mr. Hay will come back to that. 16:
21 With respect to the design of the 16:
22 Medicaid program, would you agree that the 16:
23 state has the election to go beyond the 16:
24 mandatory or minimum requirements of the 16:
25 federal government in terms of both 16:

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1 eligibility determinations and services 16:1
2 provided? 16:1
3 A. You mean, clients served as opposed to 16:1
4 eligibility determination? 16:1
5 Q. That would be fine, clients served. 16:1
6 A. Yes, the state does have that. 16:1
7 Q. In fact, in I think "Texas Medicaid in 16:
8 Perspective," there was a -- there was a 16:
9 statistic about the services provided in 16:
10 Texas at that time, 30 percent of what was 16:
11 provided was optional coverage. Do you 16:
12 recall that? 16:
13 A. I believe it references that it's technically 16:
14 optional coverage. 16:
15 Q. My point being that, do you agree, 16:
16 Ms. Friedholm, that the specifics of a 16:
17 Medicaid program is up to the state, that is, 16:
18 the design of the program is up to the state 16:
19 aside from these floors or minimums provided 16:
20 by the federal government? 16:
21 A. I don't know that I would use the generic 16:
22 term "design," but the state does have 16:
23 choices to make within the structures of the 16:
24 federal law which allows them to shape the 16:
25 way the program looks for each state. 16:

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1 Q. And each state's Medicaid program, therefore, 16:1
2 isn't going to be the same. They will differ 16:1
3 in many respects in terms of the customers or 16:1
4 clients served and the services provided. 16:1
5 A. Yes, they're all different. 16:1
6 Q. And that's up to the state how they want -- 16:1
7 who they want to serve above the floor and 16:1
8 what services they want to provide other than 16:1
9 the mandatory, correct? 16:1
10 A. Well, within the list of options that the 16:1
11 federal law allows. 16:1
12 Q. Right. Did you in your function as Texas 16:1
13 Medicaid director or in your earlier 16:1
14 positions review or attempt to determine what 16:1
15 the major pieces of legislation were that 16:1
16 improved the effectiveness or efficiency of 16:1
17 Texas Medicaid program? 16:1
18 A. I would like to think that all the things 16:1
19 that I worked on would improve the 16:1
20 effectiveness and efficiency of the program. 16:1
21 I don't know if you're referring to a 16:1
22 specific report. 16:1
23 Q. Was there any effort -- moving back to the 16:1
24 Texas Performance Reviews, Ms. Friedholm, was 16:1
25 there any effort to evaluate or determine 16:1

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1 which of the Texas Performance Review 16:1
2 recommendations were adopted and which were 16:1
3 not? 16:1
4 A. To evaluate them? 16:1
5 Q. Yes. 16:1
6 A. By whom? 16:1
7 Q. By you or anyone else, to your knowledge. 16:1
8 A. Each TPR received significant amount of 16:1
9 scrutiny and analysis. It's my recollection 16:1
10 that every single recommendation was drafted 16:1
11 into legislation and virtually all of them, 16:1
12 if not all of them, were put through a 16:1
13 legislative process. Whether they all made 16:1
14 it or not, I can't say specifically. 16:1
15 Q. Do you know of any -- strike that. 16:1
16 Did you or any of your people make 16:1
17 any assessment of the percentage or the 16:1
18 number of recommendations adopted or the 16:1
19 number not adopted and what the consequences, 16:1
20 costs or otherwise, were from not adopting 16:1
21 certain recommendations? 16:1
22 A. No, my -- we did not, no. 16:1
23 Q. Did you ever hear of what's called the score 16:1
24 card? 16:1
25 A. No. 16:1

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1 Q. You were not shown, anyway, a copy of the 16:1
2 score card? If one was available, you never 16:1
3 saw anything called a score card; is that 16:1
4 right?
5 A. I don't know what you're referring to. 16:1
6 Q. Okay. Was there ever any consideration by 16:1
7 you or the state government in terms of 16:1
8 Medicaid to treat smokers on Medicaid 16:1
9 different than nonsmokers? 16:1
10 A. No, not that I'm aware of. 16:1
11 Q. You had some testimony -- you testified in 16:1
12 response to some of Mr. Hay's questions about 16:1
13 illegal immigration or illegal aliens 16:1
14 utilizing health care services in the U.S. 16:1
15 and their treatment as Medicaid recipients. 16:1
16 Do you remember that testimony? 16:1
17 A. Generally, yes. 16:1
18 Q. What percent of Texas Medicaid dollars go to 16:1
19 nonTexans and nonU.S. Citizens, if you know? 16:1
20 A. I don't know. 16:1
21 Q. Was there ever an effort to determine what 16:1
22 that percentage was? 16:1
23 A. Yes. 16:1
24 Q. When was that done? 16:1
25 A. It's done on an ongoing basis. 16:1

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1 Q. By whom? 16:1
2 A. By the people who run the Medicaid program. 16:1
3 Q. And is it in a report of some sort? 16:1
4 A. Yes. 16:1
5 Q. Can you tell me what the title of that report 16:1
6 is? 16:1
7 A. It's a -- I don't know the title of it. It's 16:1
8 issued by the Medicaid program. 16:1
9 Q. Is it done on a yearly basis or quarterly 16:1
10 basis? 16:1
11 A. It's more frequently. It may be quarterly, 16:1
12 it may be even monthly. I'm not positive 16:1
13 about that.
14 Q. Is it published or is it something that is 16:1
15 done internally? 16:1
16 A. I believe it's internal. 16:1
17 Q. What else is on that report other than just 16:1
18 the breakout of how many dollars, Texas 16:1
19 Medicaid dollars go to illegal aliens? 16:1
20 A. The report is not focused only on that, but 16:1
21 those individuals are accounted for on a 16:1
22 separate category on that report. 16:1
23 Q. What else is included in the report? 16:1
24 A. Expenditures by all the different categories 16:1
25 of clients. 16:1

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1 Q. What kinds of categories of clients? How do 16:1
2 they break it down? 16:1
3 A. Children -- the different types of children 16:1
4 by different age and income levels, pregnant 16:1
5 women, that kind of breakout. The various 16:1
6 client groups. 16:1
7 Q. Is there anything you can give me in terms of 16:1
8 a description that if I were to ask your 16:1
9 counsel to get a copy of that, I could -- I 16:1
10 would be better able to describe it? 16:1
11 A. It's the report on -- by recipient category 16:1
12 on Medicaid expenditures by category. I 16:1
13 don't know any better way -- I don't know the 16:1
14 title of it, if it even has a title. 16:1
15 THE VIDEOGRAPHER: Excuse me. I 16:1
16 need to change videotape, please. 16:1
17 MR. FENNELL: Okay.
18 THE VIDEOGRAPHER: This is the end 16:1
19 of Tape 3. The time is 4:18 p.m. Going off 16:1
20 the record. 16:1
21 (RECESS) 16:1
22 THE VIDEOGRAPHER: The time is 4:22 16:1
23 p.m. This is Tape 4 of the deposition of 16:1
24 Ms. Friedholm. You're on the record. 16:1
25 MR. FENNELL: Ms. Friedholm, I'm 16:1

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1 going to pass the witness back to Mr. Hay. I 16:2
2 want to thank you for your time, particularly 16:2
3 on your birthday. I do appreciate that. 16:2
4 **FURTHER EXAMINATION**
5 BY MR. HAY:
6 Q. Let me direct your attention back to your 16:
7 statement of opinions or list of opinions, 16:
8 and I think we're up to the second-to-last 16:
9 paragraph on the second page, which is 16:
10 "Ms. Friedholm will also testify concerning 16:
11 the Disproportionate Share Program which 16:
12 provides reimbursement to qualified hospitals 16:
13 that serve a disproportionate share of 16:
14 low-income patients to compensate hospitals 16:
15 for revenues lost by serving needy Texans." 16:
16 Do you see that statement? 16:
17 A. Yes, I do. 16:
18 Q. Okay. Do you intend to render an opinion 16:
19 concerning the Disproportionate Share 16:
20 Program?
21 A. No. 16:
22 Q. This is what you described before as kind of 16:
23 factual testimony about the program? 16:
24 A. Just explaining it. 16:
25 Q. Okay. For simplicity's sake, I may refer to 16:

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1 the Disproportionate Share Program as the DSH 16:2
2 program. 16:2
3 A. That's fine. 16:2
4 Q. Okay. Can you just for the record kind of 16:2
5 briefly explain what the DSH program is? 16:2
6 A. In the mid 1980s Congress passed a 16:
7 requirement that states -- each state have a 16:
8 Disproportionate Share Program which would 16:
9 provide additional payments to hospitals that 16:
10 met criteria established by the state, 16:
11 approved by the feds regarding their 16:
12 disproportionate amount of work done for 16:
13 Dispro -- I mean, for Medicaid as well as for 16:
14 indigent health care or charity care, i.e. 16:
15 Individuals without a source of payment for 16:
16 their health care. 16:
17 Q. Okay. I believe -- and maybe it would be 16:
18 simpler if I just asked you to take a look at 16:
19 what you've previously produced and we've 16:
20 touched on briefly, which was the summary of 16:
21 the DSH program in Texas, that portion of 16:
22 Exhibit 2 to your deposition. Okay. I would 16:
23 like to ask you some questions about that 16:
24 document, that summary of the DSH program in 16:
25 Texas. Now, you told me previously that this 16:

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1 is something that Rick Peters prepared for 16:2
2 you? 16:2
3 A. As I recall, yes, it was Rick. 16:2
4 Q. Do you recall whether in your view this -- 16:2
5 this document is an accurate description of 16:2
6 the Texas DSH program? 16:2
7 A. As of May 4th, 1995. 16:2
8 Q. Okay. Has the program changed since then? 16:2
9 A. Yes, it has. 16:2
10 Q. In what way has it changed since May of '95? 16:2
11 A. There's a new federal requirement that went 16:2
12 into effect in Texas shortly after this which 16:2
13 placed a limit on the amount each hospital 16:2
14 could receive equal to the amount -- equal -- 16:2
15 no greater than the amount that they spent in 16:2
16 total for services to indigent, uncompensated 16:2
17 patients in Medicaid. 16:2
18 Q. And that's the cost, their actual cost as 16:2
19 opposed to their charges? 16:2
20 A. Well, cost versus charges. I don't recall. 16:2
21 Q. Okay. That's the facility specific cap 16:2
22 you're referring to? 16:2
23 A. Yes. 16:2
24 Q. Okay. Looking at this portion of Exhibit 2, 16:2
25 the first page, ~~the~~ fourth paragraph talks 16:2

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1 about "Current federal law restricts each 16:2
2 state Medicaid DSH payments to be no more 16:2
3 than the state's expenditure in FFY '92. In 16:2
4 Texas the annual federal fiscal year 16:2
5 expenditure is capped at 1.513 billion." Do 16:2
6 you see that paragraph? 16:2
7 A. Yes, I do. 16:2
8 Q. Okay. Does that mean the Texas DSH program 16:2
9 is not going to get any larger than this 16:2
10 $1.513 billion? 16:2
11 A. That's my understanding of it, yes. 16:2
12 Q. Okay. So that there's not going to be any -- 16:2
13 and that's not trended for inflation or 16:2
14 anything like that, correct? 16:2
15 A. I don't believe so. 16:2
16 Q. Okay. Have you any -- is it possible that 16:2
17 the Texas program actually is going to 16:2
18 decrease in size? 16:2
19 A. Well, I guess it's always theoretically 16:2
20 possible that it could. I'm not aware of any 16:2
21 specific things in the works. 16:2
22 Q. Okay. That's my -- was my next question. 16:2
23 Are you aware of any proposals in Congress 16:2
24 that may somehow decrease the size of the -- 16:2
25 A. Oh, yes.

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1 Q. -- DSH program? 16:2
2 A. Yes. 16:2
3 Q. Okay. What do they relate to? 16:2
4 A. Congress has been interested in reducing the 16:2
5 Disproportionate Share Program overall as a 16:2
6 means of saving money for the federal 16:2
7 budget. And I don't know if it is part of 16:2
8 this most recent budget package or not. I 16:2
9 haven't had a chance to catch up on the 16:2
10 details of the most recently signed federal 16:2
11 budget, but it certainly has been considered 16:2
12 for a number of years as one option for 16:2
13 cutting the Medicaid program. 16:2
14 Q. Has Congress had or have there been any 16:2
15 criticisms of the DSH program that play into 16:2
16 this -- play into the part for the 16:2
17 possibility of cutting back on the size of 16:2
18 the program? 16:2
19 A. Yes. 16:2
20 Q. What are those criticisms? 16:2
21 A. That some states have misused the program to 16:2
22 fund its regular budget, not its Medicaid 16:2
23 budget. That's the generic concern that has 16:2
24 been voiced or raised about some of the 16:2
25 states. 16:2

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1 Q. Any other criticisms of the DSH program that 16:2
2 you're aware of? 16:2
3 A. That -- that it's not tied to a specific way 16:2
4 for the safety net hospitals who receive it 16:2
5 to actually spend the money, that it's money 16:2
6 that goes to them for services they've 16:2
7 previously rendered and thus there's not a 16:2
8 one-to-one tie as the rest of the Medicaid 16:2
9 program has between an eligible patient and a 16:2
10 service provided. 16:2
11 Q. So in other words, there's no -- this is not, 16:2
12 this being DSH, is not a direct reimbursement 16:
13 of any hospital for patient services 16:
14 specifically? 16:
15 A. Well, it's not a one-to-one direct. It is 16:2
16 based upon the levels of services that the 16:2
17 hospitals have provided in the past, but it 16:2
18 is not tied in the same kind of way that the 16:2
19 regular Medicaid program is a payment for a 16:
20 particular Medicaid service rendered. It's a 16:
21 payment to the hospitals based on their 16:2
22 previous experience that goes into this 16:
23 formula that determines how much they should 16:
24 get. 16:
25 Q. So perhaps if you turn to the second page of 16:

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1 it, the first paragraph of that second page, 16:2
2 the last sentence says that "DSH payments are 16:2
3 different from other types of Medicaid 16:2
4 reimbursements" -- 16:2
5 A. I'm sorry. I'm not following. Where are you 16:2
6 again? 16:2
7 Q. That first paragraph. 16:2
8 A. Oh, I see. Okay. 16:2
9 Q. The last sentence, "DSH payments are not" -- 16:2
10 "are different from other types of Medicaid 16:2
11 reimbursement that hospitals receive because 16:
12 they do not directly reimburse the hospital 16:
13 for any specific patient services." Do you 16:
14 agree with that statement? 16:
15 A. Yes. 16:
16 Q. Okay. And that's what you were talking 16:
17 about. There's not -- it's not directly 16:
18 related to any particular patient service? 16:
19 A. Not on a one-to-one basis, right, no specific 16:
20 patient service. 16:
21 Q. Okay. Are there any guidelines or 16:
22 requirements as to how hospitals actually use 16:
23 DSH payments? 16:
24 A. Not from the federal level. We established 16:
25 some at the state level in 1994, called 16:

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1 conditions of participation, which laid out I 16:3
2 believe seven conditions of participation for 16:3
3 hospitals to receive disproportionate share 16:3
4 dollars. 16:3
5 Q. Well, do those conditions for participation 16:3
6 direct how a hospital has to use the DSH fund 16:3
7 that it receives? 16:3
8 A. It restricts some uses, as I recall, but it 16:3
9 does not direct them on how they have to make 16:3
10 the payment -- I mean, how they have to use 16:3
11 the funds, excuse me. 16:3
12 Q. Okay. How does it restrict them? 16:3
13 A. Well, they have to -- I'm not sure I can 16:3
14 remember right off the top of my head. As I 16:3
15 recall, the primary thing was they have to 16:3
16 report how they spend the money. 16:3
17 Q. They have to fill out a survey and tell you 16:3
18 what they used the money for, but there's no 16:3
19 limitation on how they can use the money; 16:3
20 isn't that correct?
21 A. I think that -- I think that's correct. 16:3
22 Yes.
23 Q. Let me now walk you through some of these 16:3
24 forms or these charts. And if you go to the 16:3
25 sixth page of the document -- unfortunately, 16:3

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1 they're not numbered, but you're going to 16:3
2 have to count down. It's -- there's a 16:3
3 section that seems to state on the top "Over 16:3
4 '93 DSH Survey" and it has hospital and it 16:3
5 has Lubbock and urban public subtotals and 16:3
6 then it has urban hospitals and it lists a 16:3
7 number of hospitals. Do you see the -- 16:3
8 A. Yes. 16:3
9 Q. Okay. 16:3
10 A. I believe I'm on the same page. 16:3
11 Q. And the first urban hospital listed is 16:3
12 Providence Hospital. Do you see that? 16:3
13 A. Yes. 16:3
14 Q. Okay. And then the -- after listing the 16:3
15 hospitals, there's a column that talks about 16:3
16 hospital types, and this particular column 16:3
17 has NP and then it has -- then down the list 16:3
18 it has some FP. Do you know what those 16:3
19 designations mean? 16:3
20 A. Not for profit and for profit. 16:3
21 Q. Okay. So McAllen Medical Center, which is, I 16:3
22 guess, listed here Number 116, is a 16:3
23 for-profit? 16:3
24 A. Yes, it is. 16:3
25 Q. Okay. Before the Texas Department, or before 16:3

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1 the State of Texas provides DSH funds to 16:3
2 these for-profit hospitals -- which it 16:3
3 apparently did in 1995; is that correct? 16:3
4 A. Yes, it still does. 16:3
5 Q. Okay. Does it make any effort to determine 16:3
6 the financial status of the hospital in terms 16:3
7 of how profitable it is at that point and 16:3
8 what the DSH funds are going to do to its 16:3
9 bottom line? 16:
10 A. No. It looks to what services are provided 16:
11 to Medicaid and uncompensated care patients 16:
12 and uses the same formula across the board, 16:
13 regardless of the type of hospital that it is 16:
14 to determine a payment for those -- for that 16:
15 hospital. 16:
16 Q. And it makes these payments based on that 16:
17 formula regardless of the financial status or 16:
18 position of any hospital, including the 16:
19 for-profit hospitals? 16:
20 A. It's my understanding. 16:
21 Q. If you turn to the 10th page of the document, 16:
22 which is at the top, states "Backup Work 16:
23 Sheet for Internal Use, Work Sheet 2, DSH 16:
24 Payment Historic" -- "Historical 16:
25 Information." And as I understand it, it 16:

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1 seems to be talking about the teaching 16:3
2 hospitals. Do you have that page? 16:3
3 A. Yes. 16:3
4 Q. And the -- this -- can you explain to me what 16:3
5 this chart is showing? And we can use as an 16:3
6 example U.T. Medical Branch as the first 16:3
7 item. It has "Federal fiscal year '94 16:3
8 transfer." Do you know what that refers to? 16:3
9 A. I believe it's the amount of money that they 16:3
10 transferred for disproportionate share. 16:3
11 Q. They being who? 16:3
12 A. UTMB medical branch. 16:3
13 Q. Okay. And then "Federal fiscal year '94 16:3
14 payout" and it has a number for that, which 16:3
15 happens to be the exact same number. Do you 16:3
16 know what -- do you know what that 16:3
17 represents? 16:3
18 A. That's how much they got back. 16:3
19 Q. Okay. So the University -- U.T. Medical 16:3
20 Branch paid to who or transferred to who the 16:3
21 $234 million listed there for '94? 16:3
22 A. To the Medicaid program. 16:3
23 Q. Okay. And then they were paid back from the 16:3
24 Medicaid program another $234 million in DSH 16:3
25 payments? 16:3

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1 A. Yes. 16:3
2 Q. Is that what that indicates? 16:3
3 A. Yes. 16:3
4 Q. And it appears that for both -- for all three 16:3
5 teaching hospitals for both '94 and '95, the 16:3
6 exact amount that they transferred to the 16:3
7 Medicaid program was paid -- was repaid to 16:3
8 them in DSH payments; is that correct? 16:3
9 A. Yes. 16:
10 Q. Okay. Now, the note at the bottom says that 16:
11 "Note: Dispro 2" -- those are the teaching 16:
12 hospitals, right? 16:
13 A. Yes. 16:
14 Q. Okay -- "hospitals transfer their total 16:
15 payouts." And then it says, "They get some 16:
16 payments, the remainder going to R" -- 16:
17 "R." -- excuse me, "G.R." 16:
18 A. Yes.
19 Q. Do you see that? Do you know what G.R. 16:
20 means? 16:
21 A. General revenue. 16:
22 Q. Okay. What's the remainder that they're 16:
23 referring to? 16:
24 A. I'm not sure I can say specifically. 16:
25 Q. Well, you don't have to -- I'm not asking the 16:

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1 amount. 16:3
2 A. Oh.
3 Q. I'm asking more, you know, kind of 16:3
4 conceptually what remainder. If they get -- 16:
5 whatever they transfer, they get back, what 16:
6 remainder are we talking about? 16:
7 A. The remainder would be the difference between 16:
8 what they paid in and what was drawn down, 16:
9 based on that payment. 16:
10 Q. Which would be the federal share of -- based 16:
11 on that transfer in? 16:
12 A. Yes. 16:
13 Q. Okay. So to simplify this, what is happening 16:
14 here in '94 and '95, according to this 16:
15 document, is that the teaching hospitals are 16:
16 transferring in the state share of the DSH 16:
17 payment to the DSH program. They're getting 16:
18 back that same amount, and it's generating a 16:
19 federal share that goes to the general 16:
20 revenue fund; is that correct? 16:
21 A. Well, the equivalent of it goes. I'm not 16:
22 sure -- I mean, it's not the specific 16:
23 dollars, but the equivalent of the federal 16:
24 share goes. 16:
25 Q. What is -- what's the difference? What do 16:

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1 you mean, the equivalent?
2 A. Well, it's just all -- it's all merged. It's 16:3
3 not a tracking of one to the other. 16:3
4 Q. Well, where does the money come back? I 16:3
5 mean, how does it -- where does it merge? 16:3
6 A. When it comes -- 16:3
7 Q. Just mechanically I'm trying to understand 16:3
8 what happens here. 16:3
9 A. There's a fund that when the federal funds 16:3
10 match, there's a total fund that's then used 16:3
11 to pay out to each of the different hospitals 16:3
12 an amount of disproportionate share dollars. 16:3
13 And -- 16:3
14 Q. Okay. So --
15 A. -- I may be making a distinction that's not 16:3
16 important. I was trying to clarify what you 16:3
17 were saying. 16:3
18 Q. Okay. The state puts up some fund in some 16:3
19 account, let's say, for example, that is then 16:3
20 the state's share of the Dispro program. And 16:3
21 that comes from -- in this particular case 16:3
22 from the teaching hospitals, right? 16:3
23 A. Yes. 16:3
24 Q. And that is then matched by the federal 16:3
25 share, which is roughly 65 percent? 16:3

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1 A. Roughly. 16:3
2 Q. Right. And that is all put into an account, 16:3
3 a general account, of which the teaching 16:3
4 hospitals get back the same amount that they 16:3
5 put in? 16:3
6 A. Yes. 16:3
7 Q. And the federal share portion from that 16:3
8 account ends up going to the general fund. 16:3
9 A. Yes. 16:3
10 Q. Okay. Is that how the -- this refers to '94, 16:3
11 '95. Is that how the DSH system, which I 16:3
12 guess this is DSH 2, operates today -- 16:3
13 continues to operate? 16:3
14 A. I believe so. 16:3
15 Q. Did it operate -- 16:3
16 A. Let me qualify that. I really don't know. 16:4
17 This is a decision that's made in the 16:4
18 legislative appropriations process. So this 16:4
19 was for the appropriations period of 16:4
20 '94-'95, and I'm not sure what that 16:4
21 decision was made for the appropriations for 16:4
22 '96-'97, nor am I not sure for '90 -- the 16:4
23 ones made this year. I haven't looked at it. 16:4
24 Q. Okay. What about for prior years, prior to 16:4
25 1994? Was it the same basic mechanism in 16:4

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1 which the teaching hospitals transferred in, 16:4
2 the state portion of the DSH 2 was then 16:4
3 matched by the fed, the hospitals then -- the 16:4
4 teaching hospitals then got back the same 16:4
5 amount, approximately the same amount that 16:4
6 they put in and the general fund ended up 16:4
7 with the fed's share? 16:4
8 A. No, that was not the case. I don't recall 16:4
9 the specific numbers, but they received back 16:4
10 a substantial amount of money, which then the 16:4
11 legislature just didn't fund them with as 16:4
12 much general revenue. It was kind of a 16:4
13 fungible situation. 16:4
14 Q. So in years prior to '94, it's your testimony 16:4
15 that the teaching hospitals actually got more 16:4
16 than the money they transferred in? 16:4
17 A. That is my memory, yes. That is my recall. 16:4
18 Q. Right. Do you remember how much more? 16:4
19 A. I'm sorry. I can't remember anymore. 16:4
20 Q. Okay. Do you remember what years they got 16:4
21 more? 16:4
22 A. Since we had DSH 2, which was '91, I believe. 16:4
23 Q. Okay. At least in '94 and '95, according to 16:4
24 this document and this page, is it fair to 16:4
25 say that the teaching hospitals didn't have 16:4

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1 any net revenue from DSH -- from the DSH 16:4
2 program, that they, you know, the amount that 16:4
3 they put in was actually the amount they got 16:4
4 out, so there was no net revenue? 16:4
5 A. That is a method of finance decision that the 16:4
6 legislature made. And so the answer is 16:4
7 technically that is correct, but you have to 16:4
8 also take into consideration the 16:4
9 appropriations of other state funds to them 16:4
10 and see whether they rose or were reduced. 16:4
11 Q. Well, I'm dealing with the DSH program, 16:4
12 however the State of Texas wants to do this. 16:4
13 I'm talking about the DSH program 16:4
14 specifically, and in terms of the DSH 16:4
15 program, is it fair to say for 1994 or 1995, 16:4
16 that the DSH under Dispro 2, the teaching 16:4
17 hospitals didn't receive any net DSH funds? 16:4
18 A. Yes, which is what I already responded, but 16:4
19 I'm saying it must be viewed in the context 16:4
20 of the total appropriations to those 16:4
21 entities. This is a method of finance 16:4
22 decision. 16:4
23 Q. The method -- well, the appropriation to 16:4
24 those entities are not part of the DSH 16:4
25 program, is it? The State of Texas doesn't 16:4

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1 appropriate DSH funds, does it? 16:4
2 A. Doesn't appropriate it? 16:4
3 Q. Right. DSH funds to these hospitals. 16:4
4 A. They appropriate general revenue funds -- 16:4
5 Q. They --
6 A. -- that are part of disproportionate share. 16:4
7 Q. They have -- for whatever the State of Texas 16:4
8 does for these hospitals and for whatever 16:4
9 reason they may appropriate money, that's 16:4
10 something different than the DSH program, 16:4
11 correct?
12 A. It's all taken into consideration as to the 16:4
13 total amount that they are going to receive 16:4
14 as state institutions, is what I'm trying to 16:4
15 say. 16:4
16 Q. Okay. But for purposes of the DSH program 16:4
17 and what is listed under the DSH program and, 16:4
18 in fact, is matched by the state and then 16:4
19 shows up on the HCFA 64s, the reality is that 16:4
20 these teaching hospitals didn't receive any 16:4
21 net DSH revenue in those years. 16:4
22 A. I believe that's correct. In those years. 16:4
23 Q. Okay. Is it then fair to say that for those 16:4
24 years those -- these teaching hospitals 16:4
25 didn't receive any -- strike that. 16:4

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1 What was the federal share used 16:4
2 for -- strike that. 16:4
3 You've told me that the federal 16:4
4 share that was generated from these two years 16:4
5 with respect to the Dispro 2 hospitals ended 16:4
6 up in the general revenue. Do you know how 16:4
7 that was used -- those funds were used? 16:4
8 A. I don't think that they are specifically 16:4
9 accounted for that way. 16:4
10 Q. Could you calculate how much of the federal 16:4
11 share Dispro monies that were generated from 16:4
12 this Dispro 2 for these two years went into 16:4
13 the general revenue? And I'm not asking you 16:4
14 to do it, just if you could explain to me how 16:4
15 I would do it. 16:4
16 A. You apply the two percentages of the 16:4
17 disproportionate -- of the federal -- the 16:4
18 federal matching percentage of Medicaid to a 16:4
19 figure and you multiply. 16:4
20 Q. By that you mean I would -- let's assume for 16:4
21 the sake of argument that the federal -- it's 16:4
22 a 35 state, 65 federal split. I would -- 16:4
23 A. This is the 35. 16:4
24 Q. This is the 35, and then the federal share 16:4
25 would be the 65? 16:4

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1 A. Correct. 16:4
2 Q. And that's the amount that went into the 16:4
3 general fund? 16:4
4 A. This is as an example. I don't know if those 16:4
5 are the right numbers, but ball park. 16:4
6 Q. Right, because it goes -- it fluctuates from 16:4
7 35 and 65, right. 16:4
8 Now, looking on Page 12, or the 16:
9 12th page which talks about "Backup Work 16:
10 Sheet for Internal Use, Work Sheet 2, DSH 16:
11 Payments, Historical Information, Federal 16:
12 Fiscal Year '95, Psychiatric." 16:
13 A. Uh-huh. 16:
14 Q. Okay. Do you see that? What does this chart 16:
15 represent? 16:
16 A. Disproportionate share payments to the 16:
17 various state hospitals. 16:
18 Q. The state psychiatric hospitals? 16:
19 A. Mental health hospitals, yes. 16:
20 Q. Okay. And for federal fiscal year '95, it 16:
21 has a total amount in round numbers of $285 16:
22 million. Do you see that? 16:
23 A. Yes. 16:
24 Q. Okay. That's where -- that were all -- 16:
25 that's the total amount of DSH payments made 16:

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1 to the psychiatric hospitals in '95? Is that 16:4
2 what that refers to? 16:4
3 A. Yes. The total. 16:4
4 Q. Okay. And then next to that there's a 16:4
5 transfer column. 16:4
6 A. Yes. 16:4
7 Q. What do the transfers represent? 16:4
8 A. Those are the dollars representing indigent 16:4
9 care provided by those hospitals that were 16:4
10 used to transfer into disproportionate share 16:4
11 in order to draw federal funds. 16:4
12 Q. Okay. So is this like a physical transfer of 16:4
13 money, or is this a -- or is this something 16:4
14 else? 16:4
15 A. Electronic. 16:4
16 Q. Excuse me? Electronic? 16:4
17 A. Electronic. 16:4
18 Q. Okay. So each of these hospitals are 16:4
19 transferring into the DSH program a 16:4
20 certain -- you know, these amounts listed 16:4
21 next to their hospital? 16:4
22 A. Yes. 16:4
23 Q. Right. And then there's -- 16:4
24 A. Under the transfer column. 16:4
25 Q. Right. And then there's a net -- nets 16:4

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1 amount. What does that mean? 16:4
2 A. That represents the federal share. I believe 16:4
3 if you add net plus transfer, you get total. 16:4
4 Q. Okay. 16:4
5 A. Get FFY '95 total. 16:4
6 Q. So the -- what each of these psychiatric 16:4
7 hospitals were netting was actually the 16:4
8 federal share. They paid in the state share 16:4
9 that generated a federal share and they got 16:4
10 back as a net amount? 16:4
11 A. I'm not sure that I know that specifically 16:4
12 from this chart because that's somewhat 16:4
13 unusual terminology. 16:4
14 Q. What's unusual terminology? 16:4
15 A. I don't know that that's their appropriation 16:4
16 amount. Net -- when I saw this, I thought it 16:4
17 said net as in that's the federal share. But 16:4
18 I don't know who -- you know, I don't know 16:4
19 how much of each of these amounts actually 16:4
20 went back to these hospitals. We'd have to 16:4
21 look at the appropriations bill. 16:4
22 Q. Well, am I wrong in suggesting that the net 16:4
23 amount is what the hospitals ended up with 16:
24 after considering the amount that they 16:
25 received in total DSH payments and the amount 16:

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1 that they required to transfer? 16:4
2 A. I'm not sure of the answer to that question. 16:4
3 That's what I'm saying. What net is there 16:5
4 absolutely is the federal share, but I don't 16:5
5 know which of these columns actually ended up 16:5
6 being -- if I understand your question, 16:5
7 you're asking how much did each of these 16:5
8 institutions keep. 16:5
9 Q. Correct. 16:5
10 A. And this chart doesn't tell you that. 16:5
11 Q. Well, if you add the net and the transfer, 16:5
12 that tells you what they got -- they received 16:5
13 for their particular year, right? Isn't that 16:5
14 what you told me before? 16:5
15 A. Yes. FFY '95, that's the total amount of 16:5
16 disproportionate share for that hospital. 16:5
17 Q. That that hospital received? 16:5
18 A. I don't know if they received it. 16:5
19 Q. Why wouldn't they receive it? 16:5
20 A. Because they may have that reduced through 16:5
21 the appropriations process. I know that they 16:5
22 received the transfer amount. I just don't 16:5
23 know how much of the additional dollars went 16:5
24 to them. 16:5
25 Q. Wait a minute. You know they paid the 16:5

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1 transfer amount? 16:5
2 A. Yes, and they received it. They had to have 16:5
3 it in the first place to transfer it. 16:5
4 Q. Okay. Well --
5 A. They expended it. 16:5
6 Q. They transferred it to the state for purposes 16:5
7 of the DSH program, correct? 16:5
8 A. Yes. 16:5
9 Q. That's the transfer amount. And you -- 16:5
10 you're not aware of whether or not they 16:5
11 received the federal fiscal year amounts 16:5
12 listed here? 16:
13 A. I'm not -- I'm not certain. That may be what 16:5
14 this says, but it may not be what this says. 16:5
15 Q. Okay. If that -- if they actually -- 16:5
16 that's -- if that represents the grand, for 16:5
17 example, the grand total for the state 16:
18 psychiatric hospitals at $285 million was 16:
19 what they received in total DSH payments, and 16:
20 assume -- and let's assume that that's the 16:
21 number on the HCFA 64, for example, right, 16:
22 for state psychiatric hospital DSH payments? 16:
23 A. I believe so. 16:
24 Q. Okay. And they transferred the -- in 16:
25 gross -- in grand totals $104 million, is it 16:

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1 fair to say that the $180 million is the net 16:5
2 revenues that those institutions received 16:5
3 under the DSH program for that year? 16:5
4 A. Yes. 16:5
5 Q. So even though the HCFA 64 may state that 16:5
6 $285 million was transferred to these 16:5
7 psychiatric hospitals for 1995, in fact, the 16:5
8 net revenues that they received from the 16:5
9 program was only 180 million? 16:5
10 A. No, I cannot say that. That's what I've been 16:5
11 trying to answer for you is this does not 16:5
12 reflect what total final amount they received 16:5
13 from DSH. I do not know that answer. You 16:5
14 would have to look in the appropriations act 16:5
15 to see. 16:5
16 Q. Well, this is -- were the -- is it fair to 16:5
17 say that the DSH database maintained by the 16:5
18 state would indicate the total amounts that 16:5
19 they received in DSH payments? 16:5
20 A. The total amount, yes, which in this case 16:5
21 would be 285 million. 16:5
22 Q. Right. 16:5
23 A. I'm sorry. I thought you said the 180 16:5
24 million. 16:5
25 Q. Well, wouldn't the database also indicate the 16:5

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1 amount of transfers? 16:5
2 A. Right. That's my point. 16:5
3 Q. Okay. And sitting here today, you don't know 16:5
4 if that's how this was prepared? Is that -- 16:5
5 is that what you're saying? You don't know 16:5
6 if that's -- 16:5
7 A. I'm sorry. I've gotten very confused. 16:5
8 Q. Okay. I -- this is, as you testified, was 16:
9 prepared by Mr. Peters, so I'm assuming that 16:
10 it came from the DSH database for 1995 and 16:
11 '94. Regardless of what the state has 16:
12 appropriated one way or another, this is -- 16:
13 this is the reality of what these hospitals 16:
14 received and transferred. 16:
15 A. Okay. 16:
16 Q. Okay. Is that not a fair assumption? 16:
17 A. I believe that's a fair assumption. 16:
18 Q. Okay. Based on that assumption, is it fair 16:
19 to say that the $180 million was the net 16:
20 revenues that these psychiatric hospitals 16:
21 received for DSH payments in '95? 16:
22 A. Yes. 16:
23 Q. Okay. And you move to Page 18, and it's 16:
24 "Backup Work Sheet for Internal Use, Work 16:
25 Sheet 2, DSH Payments, Historical 16:

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1		Information" -- excuse me, make it Page 23,	16:5
2		which is -- I'm cheating. I marked my	16:5
3		pages. It's about five pages from the back,	16:5
4		and it's "Backup Work Sheet for Internal Use,	16:5
5		Work Sheet 2, DSH Payments, Historical	16:5
6		Information, Federal Fiscal Year '95," and	16:5
7		then it has "Nonstate DSH" at the top. Do	16:5
8		you see that?	16:5
9	A.	I believe I'm on the same page.	16:5
10	Q.	This is kind of the grand total of an	16:5
11		earlier -- the chart begins on the preceding	16:5
12		pages, but I'm interested in the total	16:5
13		number. But the first provider is Lamb	16:5
14		Health Care Center. Do you see that?	16:5
15	A.	Yes.	16:5
16	Q.	Okay. So we're on the same page. The first	16:5
17		question I have is, this notation at the top,	16:5
18		this is "Federal Fiscal Year '95, Nonstate	16:5
19		DSH." What does that mean? What does	16:5
20		nonstate DSH mean?	16:5
21	A.	I believe these are the local district funds.	16:5
22	Q.	So these are local funds as opposed to state	16:5
23		funds; is that correct?	16:5
24	A.	That's my interpretation.	16:5
25	Q.	Okay. Now, again, at the bottom there's a	16:5

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1 grand total of approximately -- for federal 16:5
2 fiscal year '95 an amount of approximately 16:5
3 $786 million. Do you see that? 16:5
4 A. Yes. 16:5
5 Q. That would be the amount that would be on the 16:5
6 HCFA 64? 16:5
7 A. I don't know. 16:5
8 Q. You don't know? Then there's a hospital 16:5
9 transfer column, which on this particular 16:5
10 page there isn't any transfers, but on some 16:5
11 of the preceding pages, going back two or 16:5
12 three pages, I believe there were some 16:5
13 transfers listed. Do you see, like for 16:5
14 Harris County and some examples? 16:5
15 A. Uh-huh. 16:5
16 Q. Okay. So does that -- and there's no total 16:5
17 here for the hospital transfer number, but 16:5
18 those transfers that are listed there, even 16:5
19 though they're not totaled, does that 16:5
20 represent the transfers made by those local 16:5
21 hospitals to the state program? 16:5
22 A. I believe so, but I can't verify that. I 16:5
23 didn't prepare this document, and so I don't 16:5
24 feel comfortable in making representations, 16:5
25 but it appears to be. 16:5

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1 Q. Okay. And I didn't have it when I asked 16:5
2 Mr. Peters about this program, so bear with 16:5
3 me, and you're who I have now, so I will do 16:5
4 the best we can with your testimony. 16:5
5 The next column is "Hospital Net," 16:5
6 and does that column represent the net 16:5
7 revenue that the hospitals received after the 16:5
8 transfers? 16:5
9 A. It appears to, yes. 16:5
10 Q. Let me ask you this: From a provider's 16:5
11 perspective under the DSH program, is the net 16:5
12 revenue the total amount of revenue they 16:5
13 received from the DSH program for medical 16:5
14 services, medical treatment? 16:5
15 A. For medical treatment? 16:5
16 Q. Right. In any way related to medical 16:5
17 treatment. This -- and what I'm trying to 16:5
18 get to is, the column from the provider's 16:5
19 perspective, any of these providers who -- 16:5
20 these local hospitals, they have -- they do 16:5
21 have an amount for a full amount of the DSH 16:5
22 payment. Then there's a hospital transfer 16:
23 and then there's a net payment. And my point 16:
24 simply is, from the provider's perspective in 16:
25 viewing the DSH program, the additional 16:

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1 revenue that they receive for medical 16:5
2 treatment or whatever from the DSH, from the 16:5
3 DSH program is the net amount; is that 16:5
4 correct?
5 A. Yes. 16:5
6 Q. We don't know how much of it actually -- out 16:5
7 of that net amount actually goes to medical 16:5
8 treatment because there's no obligation that 16:5
9 they apply any of it to medical treatment; is 16:5
10 that correct?
11 A. Under the federal law, that's correct. 16:5
12 Q. When we've been talking about these local or 16:5
13 quote, unquote, nonstate DSH programs, we're 16:5
14 talking about really DSH 1, right? 16:5
15 A. Yes. 16:5
16 Q. Okay. Is any monies generated from the DSH 1 17:(
17 program that goes into the general revenue, 17:(
18 like as we talked about in DSH 2? 17:(
19 A. I don't believe so. 17:(
20 Q. As I understand it -- and correct me if I'm 17:(
21 wrong -- in DSH 1, the idea is that a select 17:(
22 group of hospitals put up the state's share 17:(
23 of DSH 1 and that generates the federal share 17:(
24 for DSH 1, which is then paid to those 17:(
25 hospitals and to the other hospitals in the 17:(

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1 DSH 1 program. Is that a fair restatement of 17:0
2 how the program works? 17:0
3 A. Generally, yes. 17:0
4 Q. Has the state from its general fund 17:0
5 contributed to the DSH -- strike that. 17:0
6 What was the last year that the 17:0
7 state actually appropriated money from its 17:0
8 general fund to the DSH program? 17:0
9 A. I don't know that I can remember that. 17:0
10 Q. Could it be as far back as 1989? 17:0
11 A. I don't know. 17:0
12 Q. Okay. By the way, what was your involvement 17:0
13 in the design and implementation of the DSH 17:0
14 program in Texas? 17:0
15 A. I was heavily involved in it. 17:0
16 Q. Who did you work with in that regard? 17:0
17 A. I worked with the state and the hospitals on 17:0
18 it. 17:0
19 Q. Okay. Well, who at the state, I guess, is 17:0
20 what I'm trying to understand? 17:0
21 A. With legislative staff as well as Medicaid 17:0
22 program staff. 17:0
23 Q. Have you worked with Mr. Peters with respect 17:0
24 to DSH? 17:0
25 A. Oh, yes. 17:0

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1 Q. Okay. Do you find him to be -- have you 17:0
2 found him to be knowledgeable with respect to 17:0
3 the DSH program? 17:0
4 A. Yes. 17:0
5 Q. Do you know if there's anyone in the State of 17:0
6 Texas more knowledgeable than Mr. Peters in 17:0
7 terms of the DSH program? 17:0
8 A. No, I don't think so. 17:0
9 Q. Do you know what amount of the DSH program 17:0
10 has gone to the general -- Texas general fund 17:0
11 over the years? 17:
12 A. No. 17:
13 Q. Have you seen any record that would indicate 17:
14 how much of the DSH payments ended up in the 17:
15 general fund? 17:
16 A. No. 17:
17 Q. Have DSH payments gone to the general fund 17:
18 every year that you can recall? 17:
19 A. No. 17:
20 Q. What years do you recall that they didn't? 17:
21 A. I believe 1994, '95 was the first biennium 17:
22 where that happened. 17:
23 Q. Where actual funds, DSH funds went to the 17:
24 general fund? 17:
25 A. Yes. 17:

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1 Q. How about years before that? I thought your 17:0
2 testimony was that in years prior to that for 17:0
3 the Dispro program the teaching hospitals did 17:0
4 get some money above what they transferred, 17:0
5 but still not the total federal share. 17:0
6 A. I can't say what that proportion was. It 17:0
7 was -- it may have been all of it. I don't 17:0
8 remember. 17:0
9 Q. Okay. Let me just take you back when 17:0
10 Mr. Fennell was asking you some questions 17:0
11 about the Texas Performance Reviews. You 17:0
12 said there was a section of those reviews 17:0
13 that related to DSH that you disagreed with 17:0
14 because it was factually incorrect, as I 17:0
15 understood what you said. 17:0
16 A. Yes. 17:0
17 Q. Do you -- can you describe for us what that 17:0
18 related to? 17:0
19 A. Not anymore. I could if I reviewed it, but 17:0
20 I -- carefully, but I can't just recall it 17:0
21 for you. They were recommending something 17:0
22 that was not a legal option for us, but I 17:0
23 don't recall the specifics. 17:0
24 Q. Okay. And I assume that you -- it wasn't 17:0
25 implemented then? 17:0

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1 A. Correct. 17:0
2 Q. Okay. In structuring the DSH program in 17:0
3 Texas, was there a concern about using -- or 17:0
4 ways of determining the amount of 17:0
5 uncompensated care that hospitals were 17:0
6 incurring? 17:0
7 A. Yes. 17:0
8 Q. Okay. There was a reporting problem. Is 17:0
9 that fair to say? 17:0
10 A. I think across the country there's a question 17:0
11 as to how to define uncompensated care. 17:0
12 Q. Okay. And hospitals, different hospitals 17:0
13 would define it differently, so the accuracy 17:0
14 of the numbers listed for uncompensated care 17:0
15 was always a question historically? 17:0
16 A. Within Texas, the state attempted to define 17:0
17 how they should clarify between different 17:0
18 kinds of charity care and bad debt and such, 17:0
19 and that would be reviewed. 17:0
20 Q. When did Texas do that? 17:0
21 A. It's always tried to do that. 17:0
22 Q. Well, but is it fair -- am I correct that 17:0
23 Texas was concerned in establishing the 17:
24 DSH -- the DSH program that there were a lot 17:
25 of reporting problems for uncompensated care 17:

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1 throughout the history of the program? 17:0
2 A. Well, there wasn't any reason to have 17:0
3 reporting of uncompensated care before 17:0
4 disproportionate share. So the advent of the 17:0
5 program caused a need for the state to have 17:0
6 an interest in that, and, you know, at that 17:0
7 point they started struggling with what's the 17:0
8 best way to do that. 17:0
9 Q. Right. And when they started the program, 17:0
10 they realized that hospitals were accounting 17:0
11 for it in different ways and there were just 17:0
12 general concerns about the reliability of 17:0
13 what hospitals were saying were uncompensated 17:0
14 care. Is that fair? 17:0
15 A. I have a vague -- a vague understanding of 17:0
16 all of that that's fairly technical, but yes, 17:0
17 I believe that was correct. 17:0
18 Q. And is it fair to say that in order to avoid 17:0
19 in some ways that situation, Texas came up 17:0
20 with a proxy for determining uncompensated 17:0
21 care that was somewhat different than other 17:0
22 states were utilizing? 17:0
23 A. As I recall, yes. 17:0
24 Q. Would you agree that the use of charges tends 17:0
25 to overstate the amount of care actually 17:0

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1 delivered by some hospitals? 17:0
2 A. I'd like to take a break, if we're going to 17:0
3 keep on going. It's after 5:00 o'clock 17:0
4 now --
5 Q. Okay.
6 A. -- and I've been at this since 8:00 o'clock. 17:0
7 Q. Oh, I understand. Can you just answer that 17:0
8 question and we can take a break?
9 A. If you'll repeat it. 17:0
10 Q. Okay. Would you agree that the use of 17:0
11 charges tends to overstate the amount of 17:0
12 actual care delivered by some hospitals, as 17:0
13 opposed to --
14 A. I don't know enough of the technical details 17:0
15 to be able to answer your question. 17:0
16 Q. Okay.
17 MR. HAY: Let's take a break.
18 THE VIDEOGRAPHER: The time is 5:08 17:0
19 p.m. We're going off the record. 17:0
20 (Deposition Exhibit No. 12 17:1
21 (marked for identification
22 (RECESS)
23 THE VIDEOGRAPHER: We're on the
24 record. The time is 5:15 p.m.
25 Q. Okay. The court reporter has handed you

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1 what's now been marked as Exhibit 12. And
2 this is the HCFA 64 that has been listed as
3 Item 5 for the documents that you intend --
4 you may or will rely on to form your opinions
5 in this case. And my question is, what
6 concerning this HCFA 64 document do you
7 intend to rely on?
8 A. I don't believe that I do.
9 Q. Okay. So there's nothing in it that is
10 significant in terms of your opinions?
11 A. I do not believe so. I wanted to review it
12 just to look one over again, so. . .
13 Q. Were you involved in the detailed preparation
14 of HCFA 64s when you were Medicaid director?
15 A. No, I was not.
16 Q. Okay. Do you know the process on how they
17 are prepared? And by that what I'm leading
18 to, just to alert you, is that, you know, if
19 we talk about a specific line item and how
20 the numbers for that line item are generated,
21 is that something that you would normally
22 know?
23 A. Not beyond a fairly general level.
24 Q. Did you sign some HCFA 64s when you were
25 Medicaid director?

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1 A. Yes, I did.
2 Q. Okay. What did you do to -- if anything, to
3 assure yourself of the correctness of what
4 was included in them?
5 A. I would have a discussion with the people who
6 prepared it to ask if there was anything
7 unusual or any -- I relied upon their
8 expertise.
9 Q. Okay. So you didn't do any kind of
10 independent evaluation to determine its
11 accuracy?
12 A. No, I did not.
13 Q. Are you familiar with the Medicaid recipient
14 profile database?
15 A. No.
16 Q. Do you know what kind of information that
17 database might hold?
18 A. No.
19 Q. Okay. One of the documents that you've
20 listed as documents you're relying on that
21 we've discussed generally on Monday was
22 "Medicaid Prescription for Change." Do you
23 recall that that's one of the documents
24 you're relying on for your opinions in this
25 case?

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A. Yes.

Q. Okay. What in that document specifically are you relying on?

A. I can't point to any one specific thing. I listed it as a reference document that -- that I might need to rely upon and that I reviewed, but I can't think of a specific thing that ties to a specific opinion.

Q. Okay. How about Medicaid -- "Texas Medicaid in Perspective," the Second Edition? Is there anything specific in that document that you're relying on to support your opinions, or is that again a general reference?

A. It's a general reference document.

Q. And is that also true about "Texas Medicaid in Perspective," the First Edition?

A. Yes, I believe so.

MR. HAY: I have no further questions of the witness. Thank you for your time.

THE WITNESS: Thanks.

MR. HART: Thank you, John.

THE VIDEOGRAPHER: The time is 5:20 p.m.

(DEPOSITION CLOSED)

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1 **CHANGES TO DEPOSITION**

2

3 No erasures or obliterations of any kind are to be made to the original testimony as transcribed by the deposition officer. Any changes in form or
4 substance which the witness desires to make shall be furnished to the deposition officer by the
5 witness, together with a statement of the reasons given by the witness for making such changes.
6 Please enter the page number, line number, and the reason for such change or correction.

7

8 Page/Line Correction Reason for Correction

9 _____

10 _____

11 _____

12 _____

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1 **WITNESS' SIGNATURE**

2

3 STATE OF _____)

4)

5 COUNTY OF _____)

6 I HEREBY CERTIFY that I have

7 read the foregoing deposition and that this

8 deposition, together with my corrections, is a true

9 record of my testimony given at this deposition.

10

11

12

13 _____
DEANN FRIEDHOLM

14

15

16 SUBSCRIBED AND SWORN TO

17 BEFORE ME this the _____ day of _____,

18 19____.

19

20 _____
Notary Public in and for
State of _____

21

22

23

24

25

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1 **REPORTER'S CERTIFICATE**

2 IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
3 TEXARKANA DIVISION

4 THE STATE OF TEXAS, Plaintiff	)	
5 VS.	)	
6	)	
THE AMERICAN TOBACCO COMPANY; R.J. REYNOLDS TOBACCO COMPANY; BROWN & WILLIAMSON TOBACCO CORPORATION; B.A.T. INDUSTRIES, P.L.C.; PHILIP MORRIS, INC.; LIGGETT GROUP, INC.; LORILLARD TOBACCO COMPANY, INC.; UNITED STATES TOBACCO COMPANY; HILL & KNOWLTON, INC.; THE COUNCIL FOR TOBACCO RESEARCH-USA, INC. (Successor to Tobacco Institute Research Committee); AND THE TOBACCO INSTITUTE, INC., Defendants	)	CIVIL ACTION NO. 5-96CV91
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17 *

18 DEANN FRIEDHOLM

19 *

20 I, SALLY KING, Certified Court
21 Reporter for the State of Texas, do hereby certify
22 that the facts stated by me in the caption hereof
23 are true; that the said witness did make the above
24 and foregoing answers in response to questions
25 propounded as shown; that I did, in shorthand,

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report said proceedings, and that the above and foregoing typewritten pages contain a full, true and correct computer-aided transcription of my shorthand notes taken on said occasion.

I further certify that I am not in any capacity a regular employee of the party in whose behalf this deposition is taken, nor in the regular employ of any attorney of record; and I certify that I am not interested in the cause, nor a kin or counsel to either of the parties.

WITNESS MY HAND this the 21st day of August, 1997.

Sally King

SALLY KING, CSR
Certified Court Reporter
For the State of Texas
CSR No. 2299
Expiration Date: 12-31-97

King & Fuller
400 West 15th Street, Suite 604
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